Title: ENGAGING WITH PERSISTENT MEDICALLY UNEXPLAINED PHYSICAL SYMPTOMS IN HEALTHCARE: A REALIST PSYCHOSEXUAL SERVICE EVALUATION

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Jean Somerville Penman

A thesis submitted to the University of Bedfordshire in fulfilment of the requirement for the degree of Professional Doctorate

July 2015

I dedicate this thesis to the fundamental inspiration of Dr. H. Morag Bramley and to the lived experience of Carolyn who shared so generously with me. I am profoundly grateful to my clinical supervisors, to the members of the Association of Psychosexual Nursing (1998-2015) and to my clinical and administrative teams, both past and present for their continuous support.

I gratefully acknowledge that this study would not have been possible without the sponsorship of my employer, NHS Cambridgeshire Community Services, England and the consistent support of my University of Bedfordshire academic supervisors, Professor Gurch Randhawa and Dr. Erica Cook.

I would like to thank my husband Robert, our sons and daughters and my father Paul Bramley, for their unfailing encouragement and spark.

Finally, I am truly grateful to those individuals who were willing to contribute to this study in order to broaden knowledge concerning the phenomenon of persistent physical symptoms.

Our failures open our hearts of stone and move the rigid mind space toward understanding and patience.

(Rohr, 2015)

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J.S. Penman

Abstract

In this study the phenomenon of persistent physical symptoms (PPS) has been examined by realist evaluation of research and practice. Nimnuan et al., (2001) have shown that up to 35% of patients in primary care and 66% in specialist out-patient clinics have presented with such 'medically unexplained' symptoms. The cost in medical investigation to reach diagnosis for PPS is an estimated 10% of the annual UK National Health Service budget (Bermingham et al., 2010) but poor patient outcomes prevail (Dwamena et al., 2009). Currently, PPS is linked to high comorbidity with anxiety and depression (DH 2011b) and Cognitive-Behavioural Therapy (CBT) is advised as the evidence-based treatment for PPS (IAPT, 2014). However, a shortfall in clinical skills to address PPS is also demonstrated and engagement could be improved (De Lusignan et al., 2014). Moreover, the pragmatic study of alternative therapy modalities and processes for PPS is recommended (Leichsenring, 2005). To obtain a broader knowledge of process for patients with or without co-morbidity, practice-based experience suggests that one such alternative is a brief psychodynamic intervention (STPP) for PPS.

A Realist Literature Synthesis (Wong et al. 2013) highlights effective psychotherapeutic STPP interventions in real-world circumstances in

comparison with CBT interventions for heterogenous PPS. STPP for PPS is found at least as effective as CBT, with improved engagement rates. Additionally, common factors were discovered between 'third generation' STPP and CBT for effective PPS interventions and these were developed into a preliminary cross-modality theoretical analytical framework. In the realist contextual evaluation (Pawson and Tilley, 1997) of a psychosexual service delivery, the majority of PPS sufferers were found only moderately co-morbid with anxiety and depression. For complete investigative study, clinical tools are developed providing integrative CBT/STPP principles for engagement with PPS for teaching, training and practice.

In conclusion, the findings suggest that the reflexive insider position of the realist Therapist-Evaluator facilitates systematically derived Practice-Based Evidence of PPS process, meeting recommendations of Deary et al., (2007) to explore and define process and outcomes with PPS. The findings contribute to development of a conceptual platform to support health professionals in overcoming physical/mental health barriers to addressing PPS and wider patient access to effective care (NHSE, 2014, 2015).

DECLARATION

I declare that this thesis is my own unaided work. It is being submitted for the degree of Professional Doctorate in Health Related Studies at the University of Bedfordshire.

It has not been submitted before for any degree or examination in any other University

Name of candidate: Jean Somerville Penman

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Date: July 2015

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Chapter 1: Foundations

Persistent medically unexplained physical symptoms (PPS) have been described as one of the most common problems in healthcare today. It has been shown that individuals present with PPS in 20-35% of consultations in primary care and at a mean of 52% of total specialist out-patient consultations hoping to receive a medical diagnosis and treatment to relieve their symptoms of ill health or physical dysfunction (Ring et al., 2005; Nimnuan, Hotopf and Wessely, 2001). Although the PPS are thoroughly investigated, no disease-based explanations can be found and the symptoms remain largely untreated (Smith and Dwamena, 2007). For such symptoms Persistent Physical Symptoms (PPS), is now a preferred term of the England and Wales Improving Access to Psychological Therapies (IAPT, 2014) and these are often still identified in the literature as 'medically unexplained symptoms' ('MUS'). As per records, PPS are physically over-investigated (Guthrie, 2008; Ring, 2007) and incur substantial healthcare costs, which are estimated at an annual 10% of the National Health Service budget (Bermingham et al., 2010; Burton et al., 2012).

There is little evidence of outcome satisfaction for PPS sufferers in primary care settings (Fink and Rosendahl, 2008), which now have community services to address PPS in very early stages of development (De Lusignan, Jones et al., 2013). The Department of Health England has entrusted IAPT services with redressal of PPS co-morbid with anxiety and depression by evidence-based Cognitive-Behavioural Therapy (CBT) (Creed and Barsky, 2004; IAPT, 2014). However, within IAPT pilot sites, Psychological Wellbeing Practitioners (PWPs) and CB therapists feel unprepared for this clinical task and call for skills training and specialist supervision to undertake effective work with PPS sufferers (De Lusignan, Jones et al., 2013). This begins to suggest that there is more to be done

to develop realist programme theory (Pawson, 2013) in the form of guiding principles of what works to support service development and delivery and to improve access to effective interventions for PPS. Despite the bulk of evidence found through Randomised Controlled Trials of the efficacy of CBT for PPS, researchers recommend that other therapy modalities should be examined for effectiveness in this area (Leichsenring, 2005; Kroenke, 2007). There is an agreement that more needs to be known both about the process of engagement during CBT and for Short-Term Psychodynamic Psychotherapies (STPP) than has been evidenced to date (Sollner and Schlussler, 2001; Leichsenring, 2005). These initial findings are explored in detail in Chapters 3 and 4.

A realistic research and evaluation process, as adopted in this study seeks to develop further knowledge from research and practice regarding the PPS phenomenon and its links to poor mental health. The challenge, to the development of effective PPS interventions which cross the physical and mental healthcare divide and to widen patient access, can be met in part by further exploration into the therapy process. The study of common factors of therapeutic modes of engagement between patient and therapist relevant to PPS shall aid the researcher recommendations from the literature to explore in and beyond the CBT modality for effective practice in the real world of service delivery.

1.1. Aims and objectives of the evaluation

There is a clinical need to understand more about the therapeutic mechanisms that lead to a disabling of predisposing, precipitating and perpetuating factors of PPS phenomena recommended by CBT/PPS researchers (Deary, Chalder and Sharpe, 2007) and more widely (Leichsenring, 2005). This shall be facilitated further by the development of a deeper knowledge of the mechanism of patient and therapist engagement with PPS in a particular therapy setting and its outcomes. The evaluation aims and objectives are set out below.

Aim 1: To collate and develop knowledge regarding the complex PPS phenomenon found in healthcare settings.

Objectives:

- Introduce and critically identify persistent physical symptoms (PPS) (Chapter 1)
- Define Realist Evaluation ontology and epistemology as a relevant foundation for the investigation of the literature and to generate real-world practice-based evidence (Chapter 2)
- Undertake a broad scoping of the literature on the PPS phenomenon in healthcare delivery (Chapter 3)

Aim 2: To explore the efficacy and effectiveness of brief psychodynamic interventions for PPS and contrast with CBT interventions.

Objectives:

- Critically explore the efficacy and effectiveness of interventions using the principles of short–term psychodynamic psychotherapies (STPP) through a realist approach to the literature (Chapters 2 to 4)
- Critically explore how the realist findings compare and contrast to cognitive-behavioural interventions (CBT) for PPS (Chapter 4)

Aim 3: To examine therapy process and outcomes with PPS in order to develop transferrable realist principles for clinical guidance and for underpinning service redesign.

Objectives:

- Provide an ontological and epistemological underpinning for the evaluation design (Chapter 2)
- Critically develop an ethically viable realist psychosexual counselling service evaluation design (Chapter 5)
- Provide context and service outcomes at service and caseload levels, which investigates the relationship between wellbeing and symptom severity (Chapter 6)
- By abduction, create and enhance a cross-modality, theoretically derived analytical framework for the qualitative data analysis (Chapters 5 and 7)
- To critically and reflexively derive cross-modality principles and realist tools to guide clinical process for effective engagement with PPS (Chapters 7 and 8)

Terms used in the study:

The term Persistent Physical Symptoms (PPS) is used predominantly through this project, representing the concept of 'medically unexplained symptoms' (MUS) as found in the literature, until a more accurate descriptor is found. The use of the UK term General (Medical) Practitioner (GP) applies to the Primary Care/Family Physician world-wide. The term 'therapist' is used interchangeably with 'counsellor' and 'psychotherapist' and is applicable to the role of 'clinical psychologist' in and beyond the UK. Together, these will be known as CPP. The individual referred for help is known as 'patient' meaning 'the one who suffers' and is interchangeable with 'client' used in other therapy settings. The patient may be referred to as 'he' or 'she' and these too, are interchangeable, alongside the same relating to therapist gender. Finally, the role of the author is as

Practitioner-Researcher. The term 'Therapist-Evaluator' (T-E) as opposed to the Therapist-Researcher is used for this realist service evaluation. Other operational definitions are found in Appendix 2.

1.2. Aims and objectives of Chapter 1

The aim of this chapter is to provide a foundation for the evaluation-research. This begins with an introduction to perspectives on persistent physical symptoms (PPS), current English healthcare provision for PPS. In the light of the current parameters of Evidence-Based Practice, findings in practice are considered. This is followed by an introduction to the therapist-researcher background, clinical training and development and by definitions of counselling and psychotherapy and their common factors. Finally the development of Practice-Based Evidence is considered within a realist evaluation framework.

1.2.1. Introduction to persistent physical symptoms (PPS)

When normal coping mechanisms are overwhelmed by circumstances, physical signs of stress can play out in the body (McDougall, 1989; Sidoli, 2000). Gradually, as the stressors are acknowledged and understood over a short period of time these physical symptoms have a tendency to subside. However, there is a persistent experience of pain, feelings of ill health or physical dysfunction and a subsequent search for a medical diagnosis and treatment for up to 35% of the population, who are consulting their Primary Care Physician (GP), (De Waal et al., 2004). This persistent physical symptom (PPS) phenomenon can manifest in any part of the body and can also be referred to as 'Functional Somatic Syndrome' (APA, 2000) (see Table 3.i). However, the cause of this physical phenomenon often remains hidden from both the patient and attending physician. Also the expectation remains at the level of managing the symptoms rather than a full recovery (IAPT, 2014).

1.2.2. ‘Autopoetic’ symptoms maintenance

The collected psycho-neurophysiological findings of senior clinician researchers Deary et al. (2007) have been developed into an enhanced cognitive behavioural model of a cycle of symptom maintenance, which embraces predisposing, precipitating and perpetuating factors regarding PPS (see Appendix 17). In brief summary, the model links the PPS phenomenon to predisposing and perpetuating factors such as:

- previous life stressors
- physical high threat sensitivity within the endocrine system, which ceases to down-regulate over time, causing a negative cycle of heightened anxiety, harm avoidance and increased PPS severity

These elements, according to Deary et al.’s literature review, are set within the perpetuating factors of:

- cognition
- physiological arousal
- avoidance behaviours
- social factors

This model clarifies the complexity of PPS. A holistic systematic appreciation of the individual suggests that there is a need for further research and development of treatment approaches. Research is aimed on developing knowledge regarding the mechanisms of change and how these mechansims can be delivered in heterogenous practices. For now, Deary et al.’s expanded cycle of autopoietic symptoms maintenance (2007) is considered to be a useful short-hand summary of the systems involved.

Whilst discussing the phenomenon of medically unexplained symptoms, it is acknowledged that 10% of patients experiencing persistent physical symptoms of unknown medical cause may later be found to have a previously unknown medical condition (Bermingham et al., 2010). This

point is exemplified, by the previously delayed diagnosis of the Human Immuno-Virus (HIV) leading to the Acquired Immune Deficiency Syndrome (AIDS), due to lack of knowledge of HIV and AIDS at the time. It thus becomes imperative to continue with personal and medical vigilance of any new physical changes that do not improve over time. This presents an argument for keeping psychotherapeutic interventions for PPS close to the primary care setting. The provision for patient consent to liaison with his GP, if clinically indicated, will give reassurance that treatable serious medical illness is not overlooked. Thus, in this study, the development of a three-way partnership in finding a pathway to better health is considered to be beneficial. The insights into non-medical PPS by psychoanalytic psychotherapists and psychoneurobiological research is briefly reviewed in this study in order to broaden the view of causative factors.

1.2.3. Somatisation

In a scenario in which a specific medical condition is not found, persistent medically unexplained physical symptoms (PMUPS), herein referred to as PPS for this study, have been described by the psychodynamic psychotherapy community as ‘somatisation’. This suggests that not only is a person’s normal coping mechanism overwhelmed, but that the body is expressing some form of conflict or distress deep inside the individual (McDougall, 1989). It is argued from this standpoint that an expression of internal conflict below the level of conscious awareness is communicated through the body and is worth exploring both through psychotherapy and by sensitive general medical practice (Shoenberg, 2007; Zalides, 2001).

1.2.4. The psychoneurobiological perspective

The psychoneurobiological research perspective provides physiological explanation for persistent physical symptoms, which suggests links between stress hormone release and the development of physical dysfunction. The term ‘medically unexplained’ is agreed by numerous authors as inadequate and this can be attributed to the fact that

neurobiological research now indicates the role of stress on the body and it's hormonal consequences at cell and physical functioning levels (Pert, 1997/1999). Moreover, an increase in physical debility through inflammatory responses, vulnerability to infection, to auto-immune disease and delayed physical recovery have been identified by neuro-biological researchers and psychodynamic psychotherapists (Watkins, 1997; Hellhammer and Hellhammer, 2008; Luyten et al., 2012; McEwen, 2013).

Symptoms that persist for a period of over six-months duration are referred to as persistent physical symptoms (PPS) at this stage of the research process. This PPS term, has been found to be preferred by Marks and Hunter (2015) in an e-consultation of 698 responders and is currently used by Improving Access to Psychological Therapies UK (De Lusignan, Jones et al., 2014). Additionally, the UK Government is currently suggesting that the Improved Access to Psychological Therapies (IAPT UK) initiative is ideally placed to address persistent medically unexplained physical symptoms (DH, 2011, b).

1.2.5. Improving Access to Psychological Therapies

The UK Government's initiative through the development and resourcing of 'Improving Access to Psychological Therapies' (IAPT, 2008) projected an investment of £173 million from 2008-2011 (DH, 2008) into training therapists in cognitive behavioural therapy (CBT -see definition at 1.4.1. & Appendix 2). This intervention is to be used as an exclusive therapeutic modality within a stepped care approach for anxiety and depression (Glover, Webb and Evison, 2010). Government promised an investment of a further £400 million from 2010 to 2015 to fund the expansion of IAPT services over the following 4 years into other areas. Despite this, IAPT services are not yet universally equipped across England to address persistent physical symptoms as part of the Long-term Conditions (LTC) and Medically Unexplained Symptom (MUS) initiative (DH, 2011b & 2012; De Lusignan, Jones et al., 2013/2014). Moreover, pioneering work has been undertaken in Plymouth, England to create improved pathways and

training, carrying a salutory warning that without a clinical and commissioning champion, other clinical priorities will prevail (IAPT, 2009), which may result in inadequate investment in services.

IAPT wellbeing services now offer the following stepped-care interventions for healthcare professional or self-referral:

Step 1: A telephone assessment by a psychological well-being practitioner (PWP) with monitoring for improvement or deterioration.

The PWP is trained over 25 days in their first year, which leads to 2nd step.

Step 2: PWPs provide further telephone advice, guided self-help and psycho-education groups.

Step 3: In cases of no substantial change, the PWP offers a CBT intervention or related therapy, which is to be delivered by a high intensity worker.

The high intensity worker already has a professional qualification and is given two days of CBT training per week in their first year.

Step 4: For moderate to severe or complex cases, individual clinical psychology or specialist psychotherapy is provided.

Clinical psychology or specialist psychotherapy are still, on the whole, delivered within secondary care settings or by psychiatric liaison services in the community (De Lusignan, Jones et al., 2013). For those who stay in therapy at Step 3, significant outcomes have been recorded after CBT intervention. However, the majority of those referred do not appear to engage fully with the programme and consequently, validated measures of change are often reported as incomplete across the cohort (Barkham, Hardy, and Mellor-Clark, 2010a).

IAPT UK (DoH, 2014) in their positive practice guidelines have recommended that CBT practitioners are well-equipped to address

persistent medically unexplained symptoms that are linked to anxiety and depression. The recent Pathfinder Phase 1 report of therapist perceptions and experiences of working with PPS with concurrent anxiety and depression shows an enthusiasm and willingness to undertake the work with this diverse group and gives examples of locally inspired innovative approaches. However, the need for further training is clearly articulated in the report's qualitative findings, with investment in specialist supervision to support the therapists in their work. The Pathfinder evaluation team were disappointed by the low response rate to the 'end of therapy' patient experience survey at 6% of the initial cohort (De Lusignan, Jones et al., 2013). However, according to the survey, those who attended and completed the data-sets valued the intervention and their improved physical function and well-being.

1.2.6. Evidence-Based Practice (EBP)

Department of Health instituted a health policy to provide the same or better services more efficiently and the attention to the importance of mental health for physical well-being (DH, 2011a). To achieve this, IAPT was invited in 2011 for creating pilot sites which would expand their services to include long-term conditions and medically unexplained symptoms (MUS). Also, the National Institute for Clinical Excellence (NICE) recommends exclusive Evidence-Based therapies for particular conditions. This in turn has resulted in the recommendation of CBT for long-term conditions and for persistent physical symptoms associated with anxiety and depression, to be more beneficial than usual care alone (DH 2012). This has now virtually, excluded direct access to the generic services of highly experienced primary care counsellors within the primarycare practice setting. These counsellors may use an approach, which is person-centric, brief psychodynamic or CBT techniques or some form of integration. The IAPT 'MUS' Positive Practice Guide (2014) suggests that specific low intensity interventions are required for mild to moderate persistent PPS that are not found co-morbid with anxiety and

depression. This is contrary to the Therapist-Evaluator's (T-E's) previous informal practice-based evidence which suggests that it is the skilled use of brief psychotherapeutic techniques that supports an effective resolution for this group.

An increasing number of psychotherapeutic interventions are now empirically validated indicating a wider patient choice of therapy within IAPT services. Examples include, Counselling for Depression (CfD), Interpersonal Psychotherapy (IPT), Dynamic Interpersonal Therapy (DIT) and couple therapy for depression. These evidence-based practices show that counsellors and psychotherapists, with 'top-up' trainings, are in a ready state and skilled position to undertake the Step 3 interventions (BACP, 2014) and also that those with specialist expertise in working with PPS, are ready to deliver Step 4. The term 'CBT' is found to not cover all effective interventions. It is imperative that the evidence base for PPS interventions is expanded so that it may include the findings and recommendations from naturalistic and qualitative studies in order to broaden access.

This expanded evidence will deepen an understanding of therapies applied in practice that do not yet, nor may never have the opportunity nor the suitability to be fully studied by randomised controlled trial (RCT) (Barkham and Mellor-Clark, 2003). A realist literature synthesis develops evidence that it can no longer be presumed that the results of RCTs are the only form of valid empirical evidence. CBT has been defined over and again by 'gold-standard' systematic literature reviews as the pre-eminent choice for PPS interventions as suggested by Layard (2006) and Layard, Clark, Bell et al., (2006) for anxiety and depression. When the concluding recommendations of systematic literature reviews were examined, it was found that reviewers were leaning towards widening the quality of evidence to the study of other therapies for PPS and the implementation of other than RCT research designs (Leichsenring, 2005).

1.2.7. Informal Practice-Based Evidence

Evidence from my clinical psychotherapy practice within the English National Health Service (NHS), which addressed the persistent sexual symptoms not wholly explained by medical condition, prompted a second look at the best functional treatment alternative. It was witnessed in the practice, that an early focus on persistent sexual symptoms with the use of, in the main, psychodynamic principles (for definition see 1.4.2.) leads the individual, through the process of a relatively brief intervention to a self-reported experience of change in physical function and improved well-being. A focused realist literature synthesis of Chapter 4. concurs, showing at least comparative equivalence in efficacy with CBT suggesting, with other authors of STPP efficacy, that more needs to be understood in relation to how psychotherapy works when addressing persistent physical symptoms (Sollner and Schussler, 2001; Leichsenring, 2005). The evidence from the literature and my own clinical practice acts as a foundational drive that underpins this research into exploring PPS in practice.

1.3. Introduction to researcher background

As a therapist-researcher I hold a senior accreditation with the British Association for Counselling and Psychotherapy. However, my professional expertise can be attributed to the marriage of specialist nursing and psychotherapy. For the last 18 years I have led and delivered, with colleagues, an English National Health Service (NHS) intervention that offers a focused psychotherapeutic attention to persistent sexual difficulties. With optimal utilization of extensive previous experience in general adult nursing, in acute surgical and medical intensive care and in-patient pain relief, in community health visiting and through the delivery of at least ten years of counselling in primary care, I have been able to develop a holistic view of issues relating to health and well-being. I enhanced my clinical skill set through an experiential learning

process from 1985-2011, with a group of nurse specialists who formed the Association of Psychosexual Nursing in 1998.

Psychosexual Nursing researcher Irwin (2011) gives account of the early development of psychosexual nursing with the use of oral history generated through expert witness seminars, which took place in 2008. Additionally, live case supervision through the medium of Balint style 'research-cum-training seminars' (Balint,1957) with the Association of Psychosexual Nursing (Wells, 2000) developed an increase in sensitivity and skill for addressing sexual concerns within the diverse areas of every-day specialist nursing practice. I decided to consolidate years of experiential skills development through a Masters programme in the Psychodynamics of Human Development with the British Association of Psychotherapists and Birkbeck College, University of London, 2000-2002.

1.3.1. Therapist-Researcher clinical training

Psychoanalyst Balint wanted to develop psychodynamic skills for health and social care professionals, in consideration of their struggle in practice with complex cases (Balint, 1957). The Balint-style of case reporting of a live encounter consists of a without notes, detailed, in the moment account of the physical presence and emotional impact when with the patient. In the experiential learning group, the therapist-patient relationship is examined for its emotion within the clinical encounter and its meaning is developed by the co-equal group members who are keen to advance their clinical skills and understanding of the patient's predicament. This process sheds light on the genesis and perpetuation of the presenting persistent sexual/physical symptom. The group is facilitated not by didactic teaching but by a trained group leader using briefly applied psychodynamic principles to focus the group's experience in response to the verbal description of the patient encounter and the associated feelings of the healthcare professional (HCP). By the group's parallel experience with the live encounter this develops insights into the nature of the presenting problem, sheds light into the patient's intimate relationships

and over time enhances skills for addressing sexual PPS in practice (Main, 1989).

During the training, a deep listening to the whole person, valuing the body's messages are jointly interpreted between the patient and HCP within the individual's life setting, past and present. An engagement with brief psychodynamic principles within the therapy sessions and case supervision, both help to identify core elements concerning particular, often previously hidden stressors within the individual. These are shared and acknowledged through the acknowledgement and expression of emotion (Clifford, 2000). Thus, a personal pathway to better physical and emotional health emerges.

This intervention that is applied to addressing persistent psychosexual dysfunction has yet to be explored prospectively by systematic research design (Irwin, 2002; 2009). It is important to understand at greater depth, firstly, the conditions in which these persistent physical symptoms that do not respond to medical treatment, develop and are maintained. Also, secondly, pressed by the findings from practice, to find out whether the facilitation of a journey towards better health and physical function can be explored systematically. Moreover, thirdly, to address whether it can become possible for a Therapist-Researcher within his or her own practice setting to ethically undertake to discover, through their particular intervention, evidence of what works towards the resolution of an under-explored phenomenon.

1.3.2. Introduction to the service and therapy intervention

A National Health Service (NHS, UK) psychosexual therapy/counselling provision (PSCS) is the setting of this study. The PSCS is currently commissioned county-wide by local government Health and Wellbeing Boards supported by Clinical Commissioning Groups within contraceptive and sexual health services. Within this context, persistent sexual

‘dysfunction’ that is not fully explained by medical condition of, at minimum, a six-months duration is explored with the patient. The PSCS also includes therapy to address previous childhood or adult experience of sexual abuse and assault, confusion in sexuality, body dysmorphia, gender dysphoria, and supports managing non-life threatening fetishistic and compulsive sexual behaviours within relationships. In this service setting, for therapy delivery, patients are seen individually for 50 minutes, once every three to four weeks, usually over a six to seven-month period. The initial contract can be extended if clinically indicated. The PSCS has been designed to be responsive to patient feedback for ongoing service development (Penman, 2009).

Therapists who have staffed the service over the years, by qualification, skill set and experience parameters, range in background, training and experience. Originally set up by a specialist physician trained through the Institute of Psychosexual Medicine (IPM), Dr Jaki Hunt and the Therapist Evaluator (T-E) of this study the PSCS essentially incudes, senior registered healthcare professionals with extensive practice in the NHS and either trained through the Balint method with the Association of Psychosexual Nursing registered with the British Association for Counselling and Psychotherapy, or registered with the College of Sexual and Relationship Therapists (COSRT). The therapists are of mixed gender and sexuality, within an age range of 50-60. The part-time therapists have varying emphasis on emotional and behavioural interventions to address persistent sexual symptoms within a time-limited frame.

Over the years of engaging the individual in clinical practice, behavioural interventions for psychosexual therapy are included that are tailored according to the individual (Hawton, 1985). Within the therapy sessions progressive muscle relaxation and breathing techniques may be included. Individuals are encouraged to adopt an accepting non-judgmental, self-observing approach to physical responses. In the T-E’s caseload, a raised

awareness of physical and emotional responses in the moment, either in the therapy or external to it, is developed with the individual. Aligning with the work of Zalides in General Medical Practice (2001) and Skrine (1997) addressing the blocks to sexual function, a safe place is developed within the therapy relationship for the expression of emotions that are found linked to the physical symptoms. At times, individuals have also reported the significant reduction of PPS severity and occasionally their unexpected disappearance (Penman, 2006; Wells, 2000).

1.3.3. Engaging with questions emerging from practice

If we consider that this intervention by exploration of the individual's story and relationships, with interpretation of emotion and physical changes can indeed reduce symptom severity or lead to sexual symptom resolution, then the following initial questions arise: whether

a) other PPS in the body also carry important messages, which could be used to guide therapy interventions in routine counselling and psychotherapy settings

b) our own clinic population also have other undisclosed PPS that might be useful to us during the therapy process

c) the changes reported are reflected in validated measures of outcome of symptom severity and well-being

d) a systematic scrutiny of personal practice process and outcomes show any principles for practice applicable to psychosexual therapy interventions and other healthcare settings for addressing heterogenous PPS

Internal Medicine Consultant Broom's deals with PPS in his New Zealand based internal medicine clinic. Informal case accounts within his clinic showed that it may be possible, as an integral part of the therapy process, to work directly with a number of different persistent medically unexplained physical symptoms (PPS) within a healthcare setting. Broom had trained in psychodynamic techniques and due to his positive findings in practice,

has a team of psychotherapists working for patient benefit within in his internal medicine clinic. This is illustrated by patient stories emerging within consultations (Broom, 2000). The questions above, arising from practice, initially prompted the T-E to undertake a phenomenological research study to explore the personal meaning of non-sexual PPS (Penman, 2010).

The initial empirical research findings have been shown through the phenomenological analysis of transcribed interview data. These findings reveal that the persistent physical symptoms appear linked, in each of the three cases studied, to 'unacceptable' emotions that in the past had been denied expression either by their environment or relationships (Penman, 2010). The interpretative phenomenological analysis, a method of qualitative analysis after Smith (1996), indicates that a psychotherapeutic exploration of PPS in partnership with the individual might help to reduce the stress of the previously hidden internal conflict or stress that was found. It showed that the potential foundation of a focused psychotherapy intervention is to explore the start of the PPS and any linked emotions, to appreciate natural survival mechanisms and to develop self-acceptance for the relief of any previously unexplored stress.

1.3.4. Developing personal clinical practice in the field

Since this time the T-E has grown in confidence in giving value to the body's reactions to particular circumstances and to trusting its signals, regardless of the length and severity of presenting PPS. In practice the T-E trusts that the PPS will show, within the therapy relationship, one or more core issues needing psychotherapeutic attention to resolve. Through the process of empirical research, the findings suggest that the human system, the mind, emotions and the physical body appear to be in essence, initially one could say, messaging the individual for attention (Penman, 2010). By a realist enquiry the generation of a deeper understanding, is set within context, of how therapist and patient engage

in addressing PPS. Additionally, this deeper understanding also sheds light on how this helps to gain access to symptom resolution that may generate some much needed principles for practice and enhance the quality of care for this patient group.

1.4. Definitions of counselling and psychotherapy

As stated earlier, a majority of randomised and controlled research studies (RCT) have been undertaken using Cognitive Behavioural Therapy (CBT) for common mental health disorders that are tested against treatment as usual (TAU). The difference in the number of these studies compared to other counselling and psychotherapy modalities is significant. Short-term psychodynamic psychotherapies or person-centred counselling are far less studied by RCT. The foundational approach of CBT philosophy uses staged but flexible protocols for the therapy interventions for specific mental health conditions. Adherence to the clinical protocol insinuates that the intervention, simply applied by protocol, equals the outcome.

This idea of building protocols for practice emerged through the clinical frustration of psychoanalysts within the psychoanalytic tradition of long-term therapies (Ferenczi and Rank, 1925). At the time, these therapies were getting longer and impossible to evaluate. This process of CBT development, which included protocols of treatment began with the observations of Alexander and French, (1946) and later Ellis (1962) and Beck (1967), as discussed in the next section.

1.4.1. Cognitive-Behavioural Therapies (CBT)

Aaron Beck wrote extensively about the concept and structuring of Cognitive Behaviour Therapy (CBT). CBT in part emerged from the experience of treating depression (Beck, 1967). Beck identified the relationship between the therapist and patient/client as one of joint enterprise rather than of expert to pupil (Beck et al., 1979). Further, Alford and Beck (1997) suggested that if they set up thoughts and images

(cognitions) against cognitive theory concerning emotional disorders, they could map the interacting components showing how 'emotional disorders' might have developed and been maintained over time. Thoughts and images (cognitions) are seen as influencing and they themselves are at the same time influenced by emotions, behaviour and physiology. Beck (1967) considered that each 'emotional disorder' is based in a different set of cognitions (thoughts) and therefore requires a disorder-specific adaptation of the therapy. Beck et al., (1979) found that the diagnosis of mental conditions/emotional disorders varied substantially and his pioneering work became embodied in the developed diagnostic categories within the Diagnostic Statistical Manual for Mental Health Disorders (DSM). In this instance, the DSM aimed initially, to provide clear diagnostic categories enabling unambiguous diagnosis, which meant that in turn, a CBT could be adapted to the condition. For example, anxiety suggested the need to address a fear of the world, depression - to address a negative view of the world and so on (Scott, 2009). In CBT the elements of cognition, emotion, behaviour and physiology are seen as all inter-related and in turn are affected by the individual's environment. Scott (2009) interprets this 'family' relationship of cognition, emotion, behaviour and physiology as depicted in the following illustration (Fig. 1.).

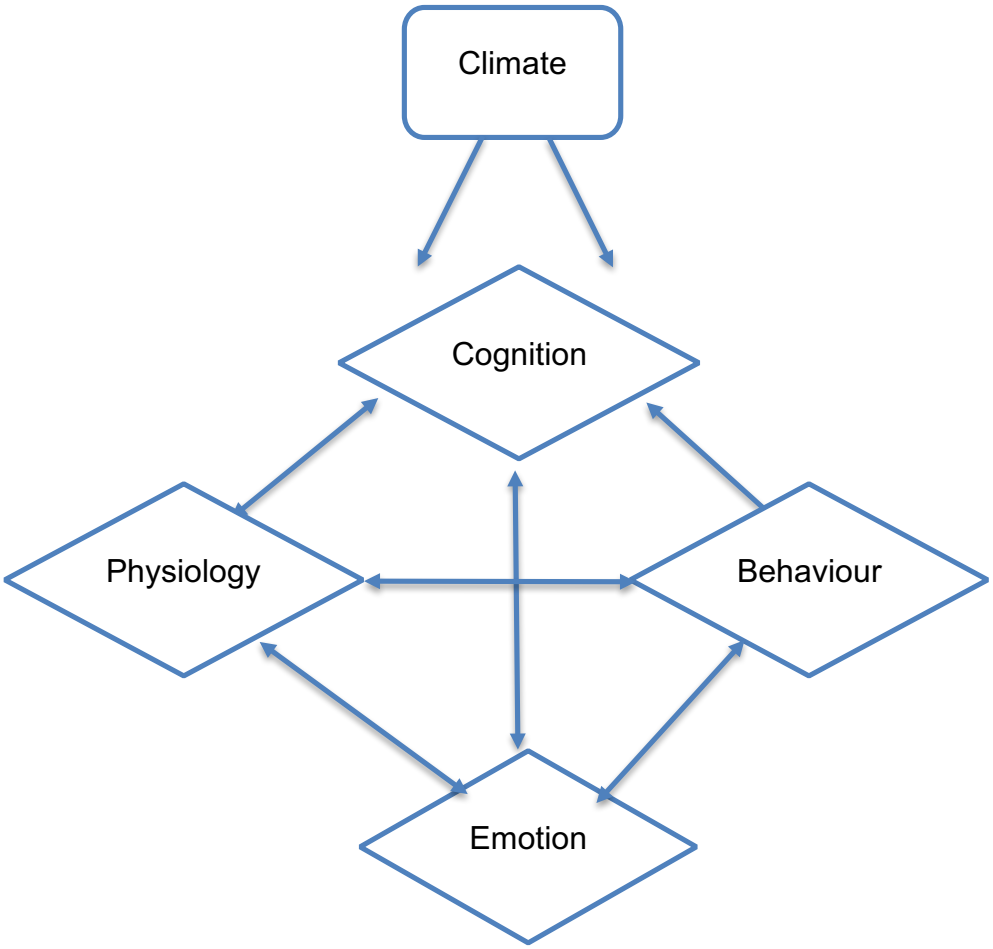

Fig. 1. Cognitive behavioural therapy: Cognitions in context (Scott, 2009)

In their outline of Cognitive Behavioural Counselling (CBC), Trower, Casey and Dryden (1988;1995) introduce the work of Albert Ellis as the second major pioneer of CBC later termed CBT. Ellis (1962) in relation to Beck's 'automatic thoughts' promoted the concept of 'irrational beliefs' in emotional disorders as harmful to the individual, preventing him from achieving his full potential and chosen goal achievement (Ellis, 1977). Ellis suggested a model called 'ABC'. It's meaning is defined in Table 1.

Table 1. The ABC Model after Trower, Casey and Dryden (1995)

cycle	Consequences
A = activating agent	e.g. Work colleague fails to acknowledge the person
B = beliefs a)inferences b) evaluation	'My colleague has ignored me.' 'He must be angry with me.' He probably dislikes me.' 'It's awful if someone dislikes you.'
C = emotional consequence behavioural consequence	Depression Future avoidance of colleague

The client's beliefs and assumptions can cause distress within a particular situation and this can affect subsequent behaviour. Beck uses the term 'automatic thoughts' as he found that the individual is often unaware of his own negative or unrealistic perspectives. Beck suggests this previously unexplored response as 'maladaptive thinking'. In very brief summary, CBT follows protocol in order to avoid an 'overly individualistic approach that is not evidence based' (Scott, 2009. p.14). Scott gives an overview of the CBT process, which is interpreted below.

Diagnosis

- by structured interview and careful use of psychometric testing

Case formulation

- considering predisposing, precipitating, perpetuating and protective factors
- checking case formulation with the client

Formulating therapeutic goals

- by discussing expectations of therapy

- clarifying goals with the client that are 'SMART' (Specific, Measurable, Achievable, Realistic and Timely)

Agreeing behavioural strategies

- setting achievable 'homework' as soon as possible to boost self-esteem and engagement in therapy

Activating the protocol: outlined by session

- Adapting the protocol to the individual's circumstances
- Focusing on modifying thoughts, beliefs and behaviours from the particular case formulation
- Testing and re-evaluating these by exposure to imagined and then real situations

For best therapy results, 10 – 20 sessions of protocol-led therapy are generally undertaken weekly or can be undertaken once a week in 6-8 sessions**.**

This section is followed by an examination of Short-Term Psychodynamic Psychotherapy (STPP) principles (1.4.2.) for comparison with the CBT process.

1.4.2. Short-term Psychodynamic Psychotherapies

Psychodynamic psychotherapies (PP) emerged amongst others, from the pioneering work of physician Charcot, with the use of hypnosis and psychological treatment for emotional conditions. Furthermore, psychologist Janet, neurologists Freud and Breuer (Shoenberg, 2007), and psychiatrist Jung (Jung, 1963/1995) all focused on interventions for the care of individuals who were troubled with brain dysfunctions and mental health difficulties.

From these early interventions, Jung recognised Freud's inference of a repressive mechanism that was below the level of consciousness (Jung, 1939). He witnessed this phenomenon in his clinical work. 'Repression', he suggested, diminished unwanted memories. As both Breuer, Freud and Jung worked at first, without a specific protocol of action, listening

attentively to the patient, they found that mysterious and disabling persistent physical symptoms would have some meaning and purpose within the individual story (Breuer and Freud, 1895/1991; Jung, 1939). This was true in Jung's personal experience, when as a boy he used to faint which was medically unexplained. This physical phenomenon occurred when Jung was due to return to school around the age of twelve. At school he had found himself bullied and misunderstood. His subsequent removal from school due to the fainting was followed by its spontaneous disappearance (Jung,1963/1995).

Subsequently, analysts such as Klein, Winnicott, Fairburn and Guntrip (McGloughlin, 1995; Shoenberg, 2007) developed another arm of the psychodynamic therapies, known as Object Relations Psychology. This 'object relations' theory developed by them, explained that human beings are shaped by the relationship with others in their environment. These relationships are internalised and shape a unique sense of the individual and his responses in the world. The individual struggles to maintain relationships with those significant others but at the same time there is a need to define the self from others (Bion, 1988). The experience of self in relationship to significant others through early life is generally expressed through the body before language is fully available to communicate any distress (Winnicott, 1958/1984 and 1989; Ogden, 2004). This has been found played out in adult relationships as shown in practice by psychoanalyst McDougall (1989) and Jungian analyst Sidoli (2000) through case examples of persistent physical symptoms or 'somatisation' brought to light in long-term analytic therapy. It was suggested both by McDougall and Sidoli that below the level of consciousness (potentially relating to Beck's term, 'automatic thoughts' seen above), old patterns are repeated and mirrored within the patient-therapist relationship. Casement, also a member of the Psycho-Analytical Society examines the dynamics of the 'helping relationship' proposing that automatic thoughts or old patterns may need to be worked through within the therapy in relation to the perpetuation of current difficulties (Casement, 1985/1997).

A key element of psychodynamic counselling is realised within the psychotherapeutic relationship. This is not by conscious control of the material, but through a trust in the containment of the setting and the longer-term process of engagement between a therapist and a patient. An understanding of repeated patterns in relationship to self and others, which undermine wellbeing and physical health can be addressed (McGloughlin, 1995). Once again, elements or patterns of the individual's dilemma are played out through the client-therapist relationship (Shedler, 2010). In a client–therapist relationship, gentle and timely interpretation is undertaken and explored.

Longer-term psychodynamic psychotherapy suggests a minimum of 40 sessions, sometimes more than weekly, and may span several years. Short–term psychodynamic psychotherapy is suggested ideally to engage the client for a period between 8-25 sessions (Shapiro et al., 1994). Levenson (2010), gives an account of brief dynamic therapy based on the fundamentals of psychodynamic theory. Brief dynamic therapist Levenson reported in her study, research that showed a median treatment length of six sessions by drop-out of open–ended therapies, suggesting a brief therapy by patient choice (i.e. by drop-out). An early proponent of the brief application of psychodynamic skills, Muran et al., (2009) argue that this drop-out from long-term therapy has remained a permanent feature since it was first noted by the publication over 50 years ago.

However, brief psychodynamic psychotherapy (STPP) is not considered to be a short version of long term PP, but includes the basic principles of psychodynamic approaches. It is acknowledged as a time limited approach, which agrees and maintains a specific focus for the therapy. It is not necessarily intended to 'cure' but to begin a process of change that continues into the future (Levenson, 2010). There are a number of STPP models that are used within the primary research papers found within the planned literature search, which is addressed in the next section. For the sake of simplicity for the purposes of this study, Shedler's (2010) seven

core techniques are presented (see Appendix 2 Psychodynamic Principles) that describe the main constituents of a psychodynamic focus. A brief Psychodynamic Psychotherapy (PP) agrees and maintains a specific focus for the therapy. These principles according to Shedler (ibid., 2010) are as follow:

- Focus on feelings and expression of emotion
- Exploration of attempts to avoid distressing thoughts and feelings
- Identifying recurring themes and patterns
- Discussion of past developmental experiences and how these shed light on current coping
- Focus in interpersonal relations in terms of understanding patterns of meeting, or not meeting, emotional needs
- Focus on the therapy relationship as a live example of patterns of relating
- Given the opportunity to explore desires, fears, and fantasies

As I considered both CBT and STPP principles for my practice, I noted that my own work was already reflected in part across both of the modalities. Consequently, a closer examination of therapy content was indicated.

1.4.3. Common factors across therapy modalities

Counselling and psychotherapy research findings were brought together following a comparative study by King et al., (2000), which showed that Counselling and CBT for depression were similar in efficacy. Research findings were more extensively explored and summarised by Cooper (2008) who advanced the case for the recognition of commonalities of 'what works' across the main psychotherapy modalities. In this examination using meta-analyses, Cooper builds the evidence that in positive outcome cases, all therapies appear equally effective in interventions. This is especially true for people referred for counselling by

a healthcare professional or by self-referral. Surprisingly, less than 1% of variance was seen due to the therapists' training modality. Norcross and Lambert (2006) previously evidenced this that less than 10% of attributed change is due to a particular psychotherapy school of training.

The 'Common Factors' (CF) relating to evidence of 'what works' in counselling and psychotherapy synthesised by Cooper (2008) shows the following material.

Demonstrably effective in face to face consultations:

- goal consensus and collaboration
- therapeutic alliance
- empathy

Promising and probably effective:

- management of countertransference (reflecting on how the therapist responds or feels about the client during therapy)
- feedback
- positive regard
- congruence
- self-disclosure
- relational interpretations
- repair of alliance ruptures

American Psychological Association acknowledges the finding that counselling and psychotherapy practices have a good deal of equivalence across modalities for common mental health disorders (APA, 2013 b). This has led to the recognition of 'common factors' that are found crossing the therapy modality divide. Thus, a further exploration of how the acknowledged common factors impact research practice for developing empirically supported therapies is needed.

Psychotherapy researchers Laska, Gurman and Wampold (2014) continue to argue the case for expanding the concept of Evidence Based Practice

that was formerly based on the (randomised) controlled trial towards developing knowledge for Empirically Supported Therapies (EST). Laska et al., (2014) argue for the inclusion within research designs of an exploration of factors that influence practice and outcomes in the real world. The American Psychological Association's Task Force supports the accounting for therapist expertise and the characteristics of patients on Evidence Based Practice (2006). This support is especially extended in the delivery of Empirically Supported Therapies (ESTs) in the real world but is nevertheless considered as unscientific (APA, 2006). In this case, Laska and colleagues argue that ESTs have to therefore show a specific mechanism of change relating to a specific scientific theory suggesting different mechanisms of action within each therapy modality. Not only this, a specific disorder must be identified in order to conduct a randomised controlled trial. The problem arises in practice on the back of this kind of research endeavor; it is presumed therefore, that one kind of psychotherapy modality for a particular condition is more effective than another kind for the same condition (Laska et al., 2014). This has not yet been tested by research and it may never be possible to test all the adaptations of even the main schools of psychotherapies to prove the case for each PPS presentation. Equally, it is evident that in the realities of practice, patients come to the physician with a number of concerns and co-morbidities that do not fall within one particular 'condition'.

The Common Factors (CF) approach as suggested by Laska and colleagues (ibid., 2014) uses the foundational work of Frank and Frank (1993) and Wampold (2001) suggesting that there are common factors, which are necessary and sufficient for change as outlined below:

- an emotionally charged bond between therapist and patient
- a confiding healing setting within which therapy takes place
- a therapist who provides a psychologically derived and culturally embedded explanation for emotional distress
- an explanation that is adaptive and found acceptable to the patient

- a set of procedures or rituals engaged by the patient and therapist that leads the patient to enact something that is positive, helpful, or adaptive

However, the list above is critiqued by Hofman and Barlow (2014) as having the potential to include 'non-bona-fide' treatments, such as 'Thought Field Therapy'. Although for example, it meets Laska et al.'s (2014) CF criteria, this therapy has been reportedly discredited by polls of expert psychologists as stated by Norcross, Koocher and Garofalo (2006). However, more recently a randomized controlled study of Thought Field Therapy for anxiety disorders, showed that significant improvement was maintained at 3 and 12 months post-intervention (Ingens et al., 2012). Moreover, an 'emotionally charged bond' in the list above might be questioned in today's therapy scenario. This is because online Cognitive Behavioural treatments with no face-to-face or 'emotionally charged bond' are beginning to be accepted as empirically supported. Constantino and Bernecker (2014) as a response to Laska and colleagues, promote their own rationale for the blending of empirically supported therapy (EST) and common factors (CF) as 'Context Responsive Psychotherapy Integration', thus taking forward a united response to uncovering mechanisms of change across therapies.

Reader and Analyst of mental health services in primary care using RCT and systematic reviews to develop and test complex interventions, with Professor of Psychological Medicine and Health Services Research (Bower and Gilbody, 2010) support this argument. They suggest that evidence-based Common Factors (CF) found across therapy interventions (Wampold and Imel, 2015) makes clear the fact that a credible theory relating to an intervention makes up only one aspect amongst other common factors that may facilitate change and improve therapy outcomes. The issue of professional judgment during the delivery of an intervention, particularly in psychotherapy practice, is noted as little examined within the paradigm of evidence-based practices (EBP), with the potential of serious

errors of judgment in its application (Bower and Gilbody, 2010). The authors also argue that the systematic examination of common factors of processes of change within psychotherapies has the potential to enhance the clinical skills across all and to reduce the unnecessary competition between therapy modalities or the requirement for skilled psychotherapists and counsellors to re-train.

1.5. Practice-based evidence

There is substantial recognition of the value of systematically developed Practice-Based Evidence (PBE) to enhance the understanding of novel approaches or insights developed in and through practice critically developed by Kazdin (2008), Professor of Psychology at Yale University. Practice-Based Evidence is now being discussed as essential to the development of a deeper understanding of how an intervention is developed over time for optimal application in the real world. This leads to a consideration of how practice-based evidence (PBE) can be generated systematically to explore 'what works' for whom and how.

1.5.1. Practice-Based Evidence and Realist evaluation

The rationale for the recognition of systematically developed Practice-Based Evidence, is to enhance knowledge developed in practice. This results in widening of the evidence base of Cochrane Systematic Literature Reviews of randomised controlled trials (RCT) (Kazdin, 2008). The previous Chair of the National Institute for Clinical Excellence, UK (Rawlins, 2008) and the American Psychological Association (APA, 2006) Presidential Task Force on Evidence-Based Practice joined forces to endorse a contextual understanding of the results of RCTs. The stimulation of new research designs from alternative paradigms of knowledge creation that can examine in detail, context and mechanisms of change are now welcomed.

Realist Evaluation (Pawson and Tilley, 2004) is explored in Chapter 2 and the description provides an example of a research framework and philosophy that embraces the real world. It offers a useful epistemology within which the components of service delivery in particular contexts can be closely examined in order to:

- increase the effectiveness of a service intervention
- support the continued development of an intervention based on real-life experience of the service provider and its recipients
- generate findings transferrable to similar contexts and practice settings
- uncover mechanisms of change

In this instance, as the therapist is also the researcher, this study requires a reflexive response to address bias in data collection and analysis, throughout the evaluation process. This is discussed in detail in Chapters 2 and 5.

1.6. Conclusion

At the outset the reader has been introduced to the concept of the persistent medically unexplained physical symptom (PPS) and the context of IAPT, UK services through which the UK Government expects PPS to be addressed by CBT. This introductory section also provides a self-introduction as a practitioner-researcher and describes how the research has been stimulated by personal findings relevant to the resolution of PPS in clinical practice with the use of psychodynamic principles. Also, the chapter offers an outline definition of the two major therapy modalities found to address PPS in research studies. These two modalities are CBT and STPP, which moreover begin to show some common factors across both the modalities.

In the light of the healthcare burden of PPS, the generation and delivery of high quality data and analysis of naturalistic practice has the potential to

develop findings for the underpinning of real world talking therapies within primary healthcare settings to widen access for patients with PPS. This is approporiate for current times, given Kazdin's (2008) urgent advice that the systematic capture and analysis of advanced practice before it is lost to retirement, is undertaken. It also takes account of the UK Government directives for effective healthcare interventions for PPS and Long Term Conditions (DH, 2012, 2014). To facilitate this, a realist research design is critically explored in Chapter 2.

Chapter 2: Realist Service Evaluation Methodology

2.1. Introduction

The UK Government suggests that psychological therapies should be woven into the treatment pathways for long-term conditions and Persistent (Medically Unexplained) Physical Symptoms (DoH, 2011b). Access to psychological services for mild to moderate PPS which is not necessarily comorbid with anxiety and depression remains inconsistent across England and Wales (De Lusignan, Jones et al., 2013). Only those with co-morbid anxiety and depression with moderate persistent symptom experience are recommended for 'high intensity' 1:1 therapy (IAPT, 2014). For all other PPS sufferers apart from the most severe, guided self-management by IAPT PWPs is recommended. Experience and research in practice convinces the T-E of the need to explore a research methodology that can legitimately broaden the current knowledge base concerning effective engagement with complex, non-ruminating individuals with mild to moderate persistent physical symptoms.

2.1.1. Aims and objectives of Chapter 2

The overall aim of this chapter is to lay the methodological foundation for the systematic and ethical synthesis of what is known about persistent physical symptoms in healthcare. This shall provide a philosophical foundation for the research/evaluation aims (1.1.) and an underpinning for the evaluation design (Aim 3, Objective 1).

The objectives of the methodology chapter include a consideration of the debate between the ideals of Evidence-Based Practice and the day to day realities of counselling, psychotherapy and psychology (CPP) interventions, followed by questions arising from the T-E's clinical practice

and experience. A focus is given to knowledge development relevant to developing counselling and psychotherapy practices and a means of capturing knowledge of practical wisdom in action. This leads to the definition of a realist ontology and epistemology and the use of current theory as a framework to underpin the generation of Practice-Based Evidence (PBE). In particular, the value of a realist approach for researching patient experience, process and outcome in context is identified. Moreover, ethical consideration of the role and conceptual positioning of the T-E in relation to PPS is made and considered within the ethical parameters for CPP research. Finally, a model of reflexivity is selected to facilitate and record the reflexive function in T-E practice and throughout the evaluation.

2.2. Evidence-Based practice and psychotherapy

'Evidence-Based Practice' in healthcare delivery aims to ensure that the recommendations of systematic reviews of controlled-trial research (RCT) or evidence of efficacy through two or more RCTs conducted by different research teams on the same subject are implemented in practice settings (NICE, 2011). Commissioners of health interventions look for replication studies within Cochrane Systematic Literature Reviews. Specifically, the Cochrane Public Health Group (2011), suggested as a quality marker, must find that an intervention can be repeated elsewhere with the same effects. However, the nature of knowledge generated by this type of evidence is the exclusion of outliers or cases of difference. These exceptions are considered to be confounding variables and are generally statistically manipulated out of intervention-outcome reports. These exceptions, that should rather than be seen as individuals who may need an adapted approach and from whom we can often learn the most, are in reality lost.

In the delivery of psychotherapy, which is based on the human relationship, commentators observe the danger of applying a common-

denominator approach to the individual (Okiishi et al., 2003). The application of RCT results that recommend a particular type of therapy for particular conditions across populations, fires the debate within psychotherapy circles as to whether the recommendations of RCTs are applicable to mixed conditions in practice. Psychotherapy researchers Roth and Fonagy (2004) argue that the exclusive use of controlled trial research, given as the most valid evidence for good outcome practice within previous National Institute for Health and Clinical Excellence, NICE guidance (2011) resulted in the near annihilation of the practice of other therapy modalities within healthcare services in the UK. It is both questioned and evidenced by practitioner-researchers that outcomes of protocol-led interventions are not necessarily evaluated as effective for practice in situ (Fonagy, Roth and Higgitt, 2005; Lambert, 2001b; Margison et al., 2000). Therapists in the real-world can find that 'Evidence-Based' practices (EBP) fall short of the complexities of individual psychotherapy relationships. This contributes to the widening research-practice gap noted by Professors of Clinical Psychology and developers of psychotherapy outcomes measures, Barkham et al., (2010b). As these authors seek to address this divide, they argue for an inclusive research strategy, harnessing the findings of efficacy, effectiveness and practice research methodologies to improve talking therapy interventions.

2.2.1. Studying therapy in practice

Barkham et al., (2010a) challenge practitioners and researchers to study therapy in practice using alternative research methodologies as a means of building a 'more complete and through' evidence-base of process and outcomes from the real world of practice.

The experienced psychotherapist is known to adapt his or her set of skills to the individual or couple presenting within the therapy setting, highlighted by counselling-researcher and psychologist McLeod (2010). This process is hidden from the outside world. Counsellors and psychotherapists have,

for many years, audio-recorded therapy sessions with patient consent in order to develop deeper insights and skills through case supervision. For research purposes, this type of every-day material is not readily available to researchers and therefore is under-examined in systematic ways (Wampold and Brown, 2005).

The publication of real-world vignettes of clinical encounters concerning individuals who search for help with intractable and troubling physical symptoms are acknowledged by longer-term psychoanalytic practitioners (McDougall, 1989; Sidoli, 2000; Shoenberg, 2007). These informally reported narrative case studies, which have been sourced from practice suggest effective but long-term approaches to the care of the individual with persistent physical symptoms.

Short-term or brief therapy encounters in Internal Medicine (Broom, 2000), General Practice (Zalides, 2001), Contraceptive and Sexual Health Clinics (Skrine, 1997) and in specialist nursing (Wells, 2000), reveal the self-reported reduction and or disappearance of persistent physical symptoms. However, these accounts do not provide enough systematically derived evidence to call the phenomenon of change in PPS in practice to a wider audience (Irwin, 2009). However, those who are in search of the Cochrane 'gold standard' evidence and base practice solely on the evidence of randomised and or controlled studies, fall short of discovering rich material of 'what works' in practice settings. Consequently, there is a pressing need for researchers and practitioners to systematically explore practice-based evidence of therapy process alongside 'before and after' measures (Lucock et al., 2003; Deary et al., (2007).

2.2.2. Pragmatic combination

Interventions that are matured and developed through practice-experienced therapists, as previously mentioned, are now recognised as being at risk of being 'lost' through lack of systematic codifying making the material inaccessible to less-experienced clinicians (Kazdin, 2008).

However, systematic codification alone omits the 'in the moment' reflection on the therapy process. The inclusion of therapist-evaluator (T-E) reflexivity on process, as shown in Chapter 8, contextualises the material in a form that is recognisable to practicing counsellors and psychotherapists. This is possible by examining the context of service delivery and the actual practice or mechanism of the therapy and its outcomes.

Barkham et al., (2012) show that validated measures of change need great care in interpretation, but in alignment with realist evaluators Pawson and Tilley (1997), argue that the pragmatic findings from practice are a vital material for policy makers to know 'what works' for whom and how. This type of pragmatic data can be used to build on and develop current theories. This evaluation of a Psychosexual Counselling Service (PSCS), shall potentially use not only validated measures of change but the codifying of qualitative data against a theoretical framework of cross-modality engagement. This shall be joined by a reflexive analysis of therapy process. Most importantly, this shall facilitate the wider potential of delivering Common Factor principles across schools of therapy (Wampold and Imel, 2015) to improve the quality of future psychotherapeutic interventions with the PPS phenomenon.

2.2.3. Questions arising from practice

There are some relevant informal findings of the T-E in psychotherapy/counselling practice over the last 18 years. These findings indicate that, what appears to be long-term intractable persistent physical symptoms, can improve and sometimes disappear altogether even during the process of a short-term therapy delivered. The duration of the short term therapy could be once a month over a period of 6-7 months. A number of questions arise from therapy and from the research literature:

- How does this happen?

- Are there any common themes that emerge within and across cases that identify mechanisms of change?
- To what extent does the routine validated self-report measures of change in persistent physical symptoms (PPS) and well-being align with each other and with the analysis of transcripts of therapy?
- How can the intervention be improved?
- How can other therapists and patients benefit from insights developed in practice?

As Kazdin (2008) concludes, the observation of clinical significance using valid and reliable measures of change cannot be the sole indicator of how outcome-data correlates with the individual's day to day living or quality of his or her relationships. The search for answers to these questions arising from practice-based experience is undertaken from a particular therapist-evaluator perspective on the phenomenon of study which is laid bare (2.5.1).

2.3. Epistemology

The nature and justification of knowledge and the relationship of the knower to what is known is described as epistemology (Carter and Little, 2007). It is interpreted differently for each research paradigm, as is briefly discussed below.

2.3.1. Positivist development of knowledge

The classic definition from the positivist research perspective that uses the quantitative measures of change as in the Randomised Controlled Trial (RCT) presents the following argument - the emotional distance between the enquirer and the human subject, with the use of a clearly specified intervention (e.g. a therapy protocol/manual) results in an unbiased, objective set of findings. Sackett et al., (1996) examined the parameters of Evidence-Based Medicine (EBM) which is founded on certain principles. One of the principles is that knowledge is 'out there' and is waiting to be

discovered by objective means. These findings remain tentative until the same (manualised) intervention can be replicated by similar large studies and find confirmation by the statistical analyses of outcome measures (NICE, 2011). The nature of this type of research has contributed substantially towards advancing medicine and science and thus the intention under the boundaries of EBM is that such evidence is used to act as a guide to clinical practice. Sackett (op. cit) suggests that if there are no or few RCTs on a particular intervention, then the next best external evidence should be followed in recognition of the fact that there are limits to the EBM 'gold standard' requirement. Tonelli, in considering the realities of respiratory care, goes further in suggesting that decisions underpinning healthcare interventions require the consideration of a combination of:

- Empirical evidence
- Experiential evidence
- Physiologic principles
- Patient and professional values
- System features

(Tonelli, 2001, p.1435)

When considering the human subject engaging in psychotherapy, Miller and Crabtree (2000) partner a debate that argues the purely positivist approach renders silent the influence of the researcher and the voice and experience of the participant. The opposing qualitative, constructivist rationale for a research methodology involving human subjects suggests that the researcher and reality are inseparable and reality can only be a subjective interpretation of events at a particular time and place in history (Denzin and Lincoln, 2011).

2.3.2. Constructivist development of knowledge

The constructivist approach is determined to give a clear voice to the influence that a researcher has on the research question, the data

collection and its analysis. Qualitative researcher Finlay (2002) argues that the interests of the researcher and his or her previous experiences influence all research. It is seen that the enquirer's perspectives on the subject, and on the research or evaluation design, on the data analysis and findings carry the potential of an unspoken or unwritten bias of personality and subjective experience. Thus, it is imperative that these are made known.

However, qualitative researchers argue that these influences can be made transparent with the use of a process of reflexivity and this subjective material can add value to the findings (Etherington, 2004). Miller and Crabtree (2000) argue further, that the qualitative research perspective, which addresses context, meaning and complexity, has much to offer. Especially in making the case for widening the vision of Evidence-Based Practice through its rich practice-based findings.

2.3.3. Developing knowledge for real-world application

Schwant (2002) of the University of Illinois gathers up the complexity on the relationship between findings generated by positivist research and professional practice in action. Professionally, when in the midst of the realities of daily work with individuals or groups, the application of theory or therapy protocols in people-based professional practice is a great challenge. This application of a therapy method, when keeping the individual as the focus, requires adaptation and modification as per individual needs. During a therapy session, problems may crop up, often without warning, and may require immediate practical action. Schwant suggests that this challenge of application of research findings has been noted across a number of professional disciplines.

2.3.4. Capturing knowledge of practical wisdom in action

As previously stated, all types of researchers have been questioning if the results of controlled trials of therapy provide with enough knowledge to expect a simple replication in routine clinical practice (Leichsenring et al., 2006). The term 'phronesis' adopted by Flyvbjerg within case study research (2011) is helpful. It captures the meaning of knowledge generation and application in the real world of practice. The author suggests that no matter how encompassing a theory, or how well-applied a protocol for an intervention, the wisdom developed through practice that is applied in action over and again, generates useful knowledge in routine clinical encounters. This process results in an enhancement of clinical skills that are generally not formally recorded (ibid., 2011). Also, both the common man and a professional reader may recognise and readily absorb accounts of real-world interventions that, in part, reveal such practical wisdom in practice. This type of account is aptly illustrated by the brief case reports that serve to illustrate the developing clinical practice of nurse-specialists and physiotherapists (Clifford, 2000) and physicians addressing the concerns of sexual dysfunction in day-to-day encounters with patients (Skrine, 1987;1997) by the use of brief psychodynamic intervention.

Also, psychoanalyst Balint (1957) diligently recorded the processes of change in healthcare engagements with patients using psychodynamic priciples, in raw verbatim accounts of 'training-cum-research' seminar groups. Moreover, the skills training for health and social care professionals as delivered by psychoanalysts Michael and Enid Balint was through guided group reflection, in confidence, on confounding medical/social presentations in primary care or community practice and focused on the practitioner-patient relationship. Informal practice-based evidence shows that the learning from practical action, through success or failure, in an on-going cycle of personal and professional reflection, builds over time on the theory generated by other forms of research, making it a

wisdom relevant to interventions within current work-loads (Main, 1989; Penman, 1998).

2.4. Realist Ontology and Epistemology: Realist Evaluation

The knowledge developed by realist evaluation is identified by Robson (2011) to be distinct from the traditionally opposing poles of positivism and relativism. Robson characterises it by the exploration of the mechanism of an intervention (the process of how and by what means) with a focus on the particular context (i.e. for which people and in what circumstances). The realist view is in essence, post-positivist, and underpinned by the pragmatics of philosopher Peirce (1839-1914). This realist view has been built upon by the philosopher Bhaskar (1944-2014) in his ontological realism and depth epistemological relativism (1975/1997). Bhaskar stressed the importance of knowledge development through a shift away from dualism, i.e. mind/body, evidence-based/little-researched which implies gaining freedom by standing back or examining closely in order to understand the whole (Bhaskar, 1998, Ch.3).

Also, realism applied suggests that the social world is considered herein as 'real' and has 'real' or profound effects on those participating and is dependent on their interpretation of it. The nature of this relationship can only ever be partially apprehended through human endeavour. Here, the social world is defined as a complex, open and dynamic system requiring a deeper exploration beneath a surface observation. This deeper exploration is done in order to get nearer to the factors that may have caused and maintained a problem. Realist researchers Greenhalgh et al., (2011), further identify the need for a deeper exploration through systems theory in which sub-systems of the social world are connected to each other and to wider systems. This reaches abstract beliefs, which in turn, form their own cultural systems that help to appreciate the individual's context and particular dilemmas. However, Bhaskar (2002) builds his philosophical realist perceptions of ontology on Peirce's underpinning

challenging through his school of Critical Realism, established ways of considering the nature of being and knowledge. On Bhaskar's death in 2014, columnist Norrie, in the Independent Newspaper wrote of Roy Bhaskar the Philosopher,

> He was concerned with thinking about underlying unities that hold humanity and nature together even in a world of splits and divisions.
>
> (Norrie, 2015, para 6)

The acknowledgement of unifying principles within the tense realities of splits and divisions is an apt underpinning for Counselling, Psychotherapy and Psychology (CPP) evaluations in context. From a realist perspective, knowledge once developed as reasonable to believe, is always open to expansion in the future. Realist Evaluation is not designed as an end in itself, but is part of a cumulative process of discovery. This philosophical perspective amongst others, informs Realistic Evaluation researchers Pawson & Tilley (1997), who build on the conceptual framework of evaluation practices of the mid 20th Century (Chelimsky,1997).

2.4.1. Context, Mechanism and Outcome

Pawson and Tilley (1997) further argue that in the real world it is not that particular interventions are said to work regardless of circumstances, but unlike the linear cause and effect proposition of experimentalists, interventions to secure change in human activity are complex. They use their example of a focus on reducing crime, for the Realist Evaluator to prove the point. It is noteworthy, that social and personal reality is not one thing, but is layered. Moreover, the nature of those involved in the intervention, an examination of the context and the value local and wider stakeholders place on the intervention, can be examined (Pawson and Tilley op. cit.). Pawson and Tilley (1997) capture the essence of Realist Evaluation in the provision of a simple equation C+M=O:

- The study of context 'C'

- Plus the study of mechanism '+ M'
- Leads to the outcome '= O'

Here, the study of context plus mechanism is suggested to lead to the outcome, otherwise known as 'CMO'. This basic tenet concerns a logic of enquiry that opens the door to an evaluation strategy and design appropriate to the subject and setting (Pawson and Tilley, 2004). A rounded evaluation of an intervention can then reveal the conditions in which the intervention would be more likely to succeed or fail elsewhere.

In realist evaluation, exploring the mechanism that leads to change in a particular context is not considered to be a controlled trial variable but as a detailed account of processes and the mechanism of their inter-relation. In general, the study of CMO using the realist evaluation begins with a particular intervention that calls for an enquiry and can be carried out prospectively, concurrently or retrospectively (Pawson and Tilley, 2004*).* A representative outline of the practical components of the Realist Evaluation Research Cycle is shown (Fig. 2.1).

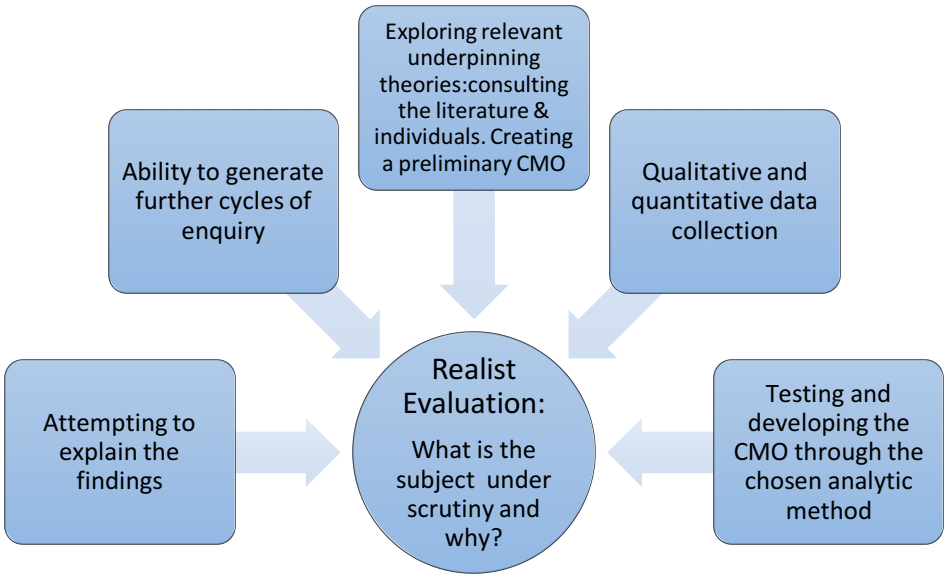

Fig. 2.1 Realist evaluation research cycles

Marchal (2012), takes a closer look at realist research studies. He critiques a lack of clarity in the use of the terms 'Context, Mechanism and Outcome'. Furthermore, researcher De Souza (2013) offers some underpinning response in the application of a critical realist perspective to the work of Pawson and Tilley on the CMO. Bhaskar (1997) and Archer's (1995) guiding meta-theoretical framework is used to view not only how society reproduces itself, but changes. De Souza proposes that a critical realist account of the power imbalance in society may dictate at an individual level, behaviours and actions that are detrimental to the individual. However, Bhaskar (1998) maintains that the agency of the individual who may be constrained in their choices to act, is not necessarily determined by or overcome by those constraints. Pawson and Tilley's (2004) realist perspective make further pragmatic suggestion that programme theories may need adjustment in relation or response to the realities of organisational, social and personal context.

This study does not however, include the wider critical realist perspective as argued by De Souza as an enhancement of Pawson and Tilley's (1997) realistic evaluation. This exploration of persistent physical symptoms (PPS) is set within the current healthcare environment, more fully understood through a realist wide and focused examination of the literature on 'what works' and explored at depth within the individual's personal context. This is with the sense that the individual, through a focused understanding and acceptance of self and other, can overcome obstacles to change to improve physical and mental wellbeing. Addressing societal, gender and political contraints are not the domain of this study. Pawson and Tilley's (2004) definition of 'mechanism' of change is here taken up by the exploration of how one or more steps within the intervention combine to lead to change for an individual or a group of individuals within their personal and social context.

Moreover, Pawson and Tilley (2004) further supported the purpose of Realist Evaluation as a means of capturing complexity in the development of a middle-range explanatory theory of the intervention aligning with the work of Stiles (2007), in his definition of theory-building from counselling and psychotherapy case studies. This type explanatory theory emerges in relation to patterns of outcomes within specific contexts and through complex processes.

Additionally, now there are examples of primary Realist Evaluations (RE) which enhance an understanding of the complexity of health care interventions. Interventions that explore context, processes and the impact of human resources in effecting a change. The knowledge developed through RE is partial but it critically enhances an understanding of what works for whom and how and in which circumstances. RE studies include specific interventions for long-term mental health conditions to improve primary care interventions (Byng, Norman and Redfern, 2005) and also the evaluation of a local birth programme comparing outcomes between different settings (Cheyne, Abhyankar and McCourt, 2013). These studies also include the study of transformation processes, for health service modernisation in Stroke, Renal and Sexual Health services (Greenhalgh et al., 2009). More recently increasing numbers of realist literature syntheses are also being conducted as essential to the realist evaluation process. The realist approach to the literature reveals findings that are generally excluded from Cochrane Standard Systematic Literature Reviews.

2.4.2. Realist Literature Synthesis

Greenhalgh et al., (2011) prepared mechanisms for consultation regarding the proposed development of standards for future realist literature reviews. These reviews are gradually growing in number, enhancing knowledge in evidencing ‘what works’, for whom and in what circumstances. Booth, Papioannou and Sutton (2011) have a special interest in exploring different kinds of systematic literature review, and consequently they

return to Pawson's (2006) foundational perspective that realist 'synthesis' of the literature is a preferred term rather than realist review.

In healthcare, realist synthesis findings contribute in developing the argument for broadening the knowledge base of Evidence-Based Practice (EBP) beyond the Randomised Controlled Trial (RCT). These findings provide practically useful, systematically derived evidence to enhance interventions involving a human response within healthcare structures. As an example, a realist synthesis of the research literature (Wong, Greenhalgh and Pawson, 2010) attempted to identify context, intervention mechanism and outcome of medical students' response to online training through an examination of the wider literature base (ie. wider than RCT findings). This type of literature synthesis showed the potential to result in immediate guidance on what works better, in what circumstances and for whom; this is well in advance of the accumulation of enough RCTs to provide evidence of efficacy on the content of one online training programme. In this example of a realist literature synthesis, online training developers and commissioners of electronic-learning programmes gain vital knowledge (Wong et al., 2010).

The standards for conducting a rigorous realist synthesis of the literature are found published by Westhorp et al., (2013) (see Appendix 13). The following chapters attempt to follow these standards describing,

a) a realist background search and synthesis of the literature underpinning engagement with persistent physical symptoms within healthcare (Chapter 3) and b) a focused realist literature synthesis, underpinned by the background search, examining short-term psychodynamic psychotherapies for PPS in Primary/Community healthcare settings (Chapter 4).

2.4.3. Theory-based realist evaluation

Part purpose of the realist evaluation (RE) is to affirm or disconfirm the theory behind an intervention, such theory is known as 'programme theory'

(Pawson and Tilley, 2004) which finds itself refined through Realist Evaluation, thus showing the principles of adaptation to meet local circumstances.

In this realist service evaluation (RSE) a preliminary framework on which to build the analysis, as outlined by Greenhalgh et al., (2011), shall be formed from the local 'rules' of the therapy intervention under examination, as informed by current theoretical perspectives and research. This holds the potential to enhance the transferability and application of findings into the real world of integrative psychotherapeutic practice. The realist literature synthesis of this study (Chapters 3 and 4) shall facilitate the development of an evidence-based theoretically underpinned preliminary analytic framework of themes of engagement between therapist and patient, ready for testing. Pawson and Tilley (1997, p.68) further argue that the discovered 'mechanism' of change itself can become an explanatory theory. It is suggested by the authors that although the data analysis, exposure of shortcomings and final conclusions of a realist evaluation are partial, the findings from the real world can be of positive help in influencing policy and practice for the commissioning and delivery of interventions. In this case, it concerns the reality of addressing mixed presentations of persistent physical symptoms in heterogenous counselling and psychotherapy practices, particularly in primary healthcare settings.

2.4.4. The logic of data analysis and abductive construction of meaning

Realist evaluators argue that the logic of the analysis of the data gathered, has been obtained through comparison between the common patterns and differences within the same programme intervention or between different groups or settings (Westhorp et al., 2011) precluding the need for control groups. Tavory and Timmermans' (2014) research exploration and definition of abductive analysis takes on a 'recursive' movement, back and forth between observation and theoretical generalisation, and embraces

the unexpected against a background of existing theories rather than one theory alone. Tavory and Timmermans argue in opposition to the logic of falsification of philosopher Popper (1902-1992) (Thorton, 2014). Based on Peirce, they argue that there is subsequently no divide between discovery and the logic of justification, and both belong to scientific work and the philosophy of science. In summary, the goal of a realist evaluator is to explain interesting and puzzling 'regularities, associations, outcomes and patterns' of a phenomenon requiring attention (Pawson and Tilley, 1997, p.68) and to learn from the observed exceptions.

2.5. Generating Practice-Based Evidence (PBE)

Introduced in Chapter 1, practice-based evidence is shown to be gaining ground as a valuable resource for broadening the current research-base for service enhancement and the development of the talking-therapies (Barkham and Mellor-Clark, 2003). This is reiterated by expert reviewers of psychodynamic psychotherapy research outcomes. Fonagy et al., (2005) assert that for individual conditions currently addressed across the world it will never be possible to undertake RCTs on all psychotherapy interventions, let alone on all the variables of the psychotherapy relationship and events that are external to the therapy hour. However, they suggest that a partnership can be forged between the different research paradigms in order to enhance the findings of evidence-based practice (ibid., 2005)

Further to the systematic examination of practice, qualitative researcher Shaw (1999) suggests that undertaking an evaluation of an intervention is a moral and practical activity, exposing for study what happens in a particular setting at a particular time. Kazdin (2008) as cited above, when referring to the generation of practice-based evidence, leans more towards a post-positivist view of knowledge creation. This combines validated measures of change and draws from the constructivist perspective when qualitative data is being analysed. This latter perspective is highlighted in

its potential value by the systematically generated, practice-based evidence of a particular psychological therapies service in South-West Yorkshire using measures alone (Lucock et al., 2003). Lucock et al. (2003), identify the value of using routine measures and critiquing these as part of service evaluation. They also recommend the generation of qualitative data of patient experience in order to give a broader and richer account of what works and why.

With reference to research into the T-E's own therapy practice, O'Leary (2005) suggests that practice-based enquiry can be for modifying, refining and improving practice. This view is in alignment with the professional guidelines for ethical practice of the British Association for Counselling and Psychotherapy (BACP) of which the T-E is a senior accredited member. This membership holds accredited members to a 'duty of care', to develop the quality of work with the individual and across services (BACP, 2013).

Furthermore, the American Psychological Association (APA) Presidential Task Force on Evidence-Based Practice (2006) discusses the value of knowledge development from non-positivistic but systematic and rigorous alternative research methodologies. As stated earlier, Rawlins, the previous chairperson of the National Institute of Clinical Excellence (NICE, UK), called for an abandonment of the 'gold-standard' hierarchy of evidence instead promoting a 'teleo-analysis' of phenomena, meaning complete or thorough exploration (Rawlins, 2008). This adds further justification for systematically generating practice-based evidence.

Moreover, real-world researcher Robson (2011) argues that the generation of knowledge from naturalistic practice can be undertaken by

a) a practitioner
b) the undergraduate or post-graduate researcher
c) a team of researchers.

Robson further identifies useful pointers to addressing the challenges of developing and communicating any findings from real-world research:

- The need for a flexible methodological design for the enquiry
- An engagement in multiple data collection methods
- Allowing for the possibility that not all variables need to be accounted for
- The need to manage personal experiences, insights and biases
- Keeping stakeholders in mind
- Being prepared for prejudice against you as a researcher/evaluator
- The need for an increase in the quality of your communication skills
- To be prepared for real-world need for contingencies
- To make clear how the findings can be audited for credible data and developing trustworthy results

Barkham and colleagues' (2010b) guidance for developing and delivering practice-based evidence outlines an adaptation from Shadish who was concerned with research within naturalistic conditions, that practice-based psychotherapy and counselling studies generally have the following broad features:

- carried out in community or primary care settings
- non-manualised
- involvement of experienced therapists not trained specifically prior to the study
- having a relatively unselected consecutively referred group of participants from routine practice

from which a sub-sample can later be selected for building a particular in-depth knowledge (Adapted from Shadish, 1997 cited in Barkham et al., 2010b, p.40).

2.5.1. Researching patient experience, process and outcome

Researching the practice of colleagues was considered. However, at this stage it was not feasible to study other therapists' interventions on this topic. This was because the T-E was unaware of any therapist at the time

(although this may be happening tacitly in practice) who purposefully would address and measure change in PPS severity, during the natural course of a short-term counselling or psychotherapy contract. More so, particularly in the early phase of therapy that would have been delivered within a primary or community healthcare setting. At the time, having scoured the primary studies within the Sex and Relationship Therapy Journal over the previous 10 years, the T-E had no current knowledge of any such therapists in the UK actively delivering psychosexual therapy interventions with concurrent attention to sexual problems conceptualised as PPS or other persistent physical symptoms in primary care or community healthcare settings.

Moreover, on research, those clinical researchers who had undertaken primary randomised-controlled trials for efficacy or conducted before and after longitudinal studies of effectiveness of interventions of short-term psychodynamic therapy for PPS of Chapter 4.4.1. were found to be:

- in out-patient settings (Creed et al., 2008; Junkert-Tress et al., 2001; Mayor et al., 2010)
- using STPP as a minor part of a specialist intervention i.e. Dance Movement Psychotherapy (Payne and Stott, 2010)
- in private practice (Ventegodt et al., 2007)
- not known to have generated further service development involving counsellors in primary care after their published research findings (Guthrie et al., 2004).

In addition, counselling researcher and practitioner McLeod (2010) discusses the types of therapy research that have been published, which attempts to explore the processes and experiences of psychotherapy/counselling. He cites the development of research methods, which aim to draw closer to what was happening in counselling and psychotherapy practice.

Researchers Strupp and Binder (1984) examined the psychodynamic psychotherapy patient experience by questionnaires after therapy-ending. This method produced data through the personal memory of the client, which is considered to be unreliable, not in general, but in the detail of the account of what happened. In order to get closer to the subject, also attempts were later made to undertake an exploration by questionnaire immediately after each therapy session by therapist and or patient, after the session (Orlinsky and Howard,1975). However, more recently, this 'after session' report (mentioned above) has been undertaken in combination with a devised in-depth semi-structured interview at therapy-end (Elliott et al., 2001) and by quantitative within-case measures (Hill, 1989). Also, reliance on subjective memory was supported by the validated measures of change, but this in essence got no nearer to understanding the therapy process itself. Attempts to capture process and experience described above have been systematic but critiqued for the 'loss in translation' or 'smoothing effect' of after the moment accounts of what happened (McLeod, 2010) and needed a further, within-therapy component.

2.5.2. The Systematic Case Study and Realist Service Evaluation

The need to examine 'what actually happens' in practice is now addressed by the protocol for Systematic Case Study for (Pluralistic) Counselling and Psychotherapy (McLeod and Cooper, 2011). Live audio or video recording of therapy sessions along with validated measures of outcome and 'end of therapy' interview are also suggested for clarity of therapy sessions. The protocol was developed through the survey of all systematic psychotherapy research methodologies (McLeod, 2010) to give boundary to a structure of greater relevance and rigour for psychotherapy and counselling case research by therapist-researchers in the field. Hill (1989) uses a substantial research team for her systematic psychotherapy case study research who are both familiar with the lead researcher and

with the methodology. The team undertakes a collaborative analysis of the data.

Unfortunately, the requirement of an end of therapy interview and the team-based constructivist method for data analysis was: a) not feasible for me to undertake within the current university context. Primarily, as access to the academic clinical practitioners experienced in the use of the Systematic Case Study for (Pluralistic) Counselling and Psychotherapy was not realistically possible, b) the process of collaborative analysis by a research team as suggested by Hill was not suited to my academic examination as a Professional Doctorate student and c) the T-E was not given NHS ethical committee permission to include an end of therapy interview undertaken by a third party with the participants. Nevertheless, elements of the psychotherapy systematic case study methodology (McLeod and Cooper, 2011) shall be drawn upon during the analytic scrutiny of the selected cases of the intervention within the realist service evaluation.

Nevertheless, Service Evaluation carries the potential to situate the depth case study in context within psychotherapy services. Service Evaluation is defined in general as a set of procedures to judge a pilot's merit as to whether it should be continued (See Appendix 10, R&D Forum). It involves a systematic assessment of the aims, objectives, activities, outputs and outcomes of an intervention. Moreover, pluralistic strategies can be used for data collection, through qualitative exploration of process and outcome and the use of validated quantitative outcome measures (Pawson and Tilley, 2006) bringing us back to the pluralist approach of the systematic case study for counselling and psychotherapy (McLeod and Cooper, 2011). However, there is the warning that the data collected must be tailored to the individual enquiry (Pawson and Tilley, 2004) and this shall be critically embraced in the research methods (Chapter 5). In the light of this, the overall frame of a Realist Service Evaluation (RSE) which embraces the evaluator's clinical practice intervention, delivers a

methodological underpinning for this research. RSE is found to broaden an appreciation of the contextual conditions and depth knowledge created by the psychotherapy case study, making comparisons where possible, with similar services and psychotherapeutic interventions.

2.6. Ethical Considerations: the role of Therapist-Evaluator

From the position of the positivist researcher, in search for an objective 'truth' by seeking to eliminate human subjectivity, the proposed realist service evaluation methodology, which uses the therapist as a lead evaluator may be questioned due to personal bias and assumptions based on practice experience. Pawson and Tilley (1997) and Shaw (1999) develop a critique, which responds to this issue: from the pure empiricist evaluation to the pure constructivist, from the pragmatist and pluralistic perspectives on evaluation, all paradigmatic approaches are considered flawed and contain bias in some way or another.

Shaw (ibid.,), as a qualitative researcher, highlights the benefits of the insider researcher, such as his or her innate knowledge of the setting and access to their own thoughts and feelings whilst engaging in their interventions. But he concludes with Hammersley (1993) that no enquirer position whether as a teacher or a researcher, necessarily guarantees the production of valid knowledge and equally no position prevents it. Thus, it becomes necessary to put checks and balances in place to reduce researcher bias in all forms of research and evaluation enquiry. Therefore, an account is given of the Therapist-Evaluator's perspectives to ensure transparency and to expose potential bias.

2.6.1. The positioning of the Therapist-Evaluator

I articulate the conceptual underpinning of my psychotherapeutic practice to alert the reader to personal bias and how this personal perspective on Persistent Physical Symptoms (PPS) has influenced the development of the research design, its methodology and methods. I have identified that I

come from a brief counselling/psychotherapy therapy background informed by years of experience in acute and community specialist nursing roles, in Primary Care Counselling and in delivering a specialist psychotherapeutic intervention for persistent sexual symptoms (Penman, 2009). My training, concurrent throughout, involved experientially acquiring proficiency in the practice of psychodynamic principles in time-limited encounters, under skilled supervision (Clifford, 2000). Further, I enhanced my skills through supervised training of healthcare professionals by the same method.

In order to fully appreciate the work in hand, the body and personal relationships are valued as central to the psychotherapeutic work with the individual or couple. With a singular focus on the start of the problem, whatever form the problem takes, and by facilitating an expression of its related emotions, the therapist reflects on personal physical and emotional responses to the encounter. These reflections are tentatively brought into the moment or after the moment in therapy either through verbal or non-verbal means. The idea is to inform the work and to keep the focus that the patient has identified (Casement, 1985/1997; Draper, 1982). Further reflexive function, added to the research design (see section 2.7.), takes place at the level of regular clinical case, group supervision. This facilitates the therapist and patient to develop insights into the persistent physical symptom and to discover a unique pathway towards the individuals' goals (Zalides, 2001).

The Therapist-Evaluator's pre-conceptions concerning persistent physical symptoms are laid out below as broad principles:

2.6.1.i. Rebalancing the system

The conundrum of persistent physical symptoms of illness or dysfunction that cannot be explained by disease process is nothing new. Hippocrates, (500-400 BC) the ancient world Greek philosopher concerned himself amongst other things, with the observation of sickness (Shoenberg, 2007).

He suggested from his observations, that every feeling can affect an organ either positively or negatively. In much simplified form, Hippocrates suggested that health was a state of maintaining an equilibrium between bodily systems and temperament. The healer's job was to restore the balance of bodily 'humours', remarking that as doctors separate mind from body, opportunities for healing mysterious signs of ill health are lost. The underpinning of this broad observation is found in my own clinical practice when giving time to explore in partnership with the individual, the 'whole' person and his story. The physical dysfunction without organic cause (PPS) becomes a rich area for exploration and understanding of personal meaning as a guide to working towards regaining a 'good enough' equilibrium (Penman, 2010).

The medical model, which has fluctuated between the holistic view of the family physician to the extremes of super-specialism over the last century until today, disables an engagement with the whole person and his story. (Bermingham et al. 2010). Shoenberg, (2007) is a psychoanalyst who engaged with individuals with persistent physical symptoms, which remain 'medically unexplained'. He suggests the powerful effects of linking 'psyche' (the mind) with 'soma' (the body) and allowing for the emotions of both the patient and the therapist to be acknowledged and explored (Shoenberg, 2007). This view is in tune with the seminal work of Michael and Enid Balint, (Balint, 1957) identified in Chapter 1, as they encouraged the transfer of psychoanalytic skills into day-to-day professional health care consultations with patients who were, within the medical model, 'hard to treat'. This embrace of mind, body and emotion and the development of a fresh non-judgmental appreciation of the self constitute the basis of my clinical practice.

2.6.1.ii. Symbolic representation

I record, the evidence of day-to-day therapy interventions for persistent sexual symptoms. These findings show that the physical 'dysfunction' set

within the individual's story, at times, appears as a symbolic representation of an underlying previously unacknowledged conflict; something is not right inside. The so-called 'dysfunction' seems to paradoxically protect to enable survival as the human system comes under serious stress but this innate self-protection also causes interpersonal or physical difficulties when the need to defend against danger is no longer required (Broom, 2000; Zalides, 2001).

Again this paradoxical finding as mentioned above is not newly observed. It is underpinned by the observations in clinical practice of physicians Janet, Charcot, Breuer, and physician psychoanalysts Freud and Jung and others of the late 19th, early 20th centuries (Shoenberg, 2007). Stressful conflicting life situations, beyond the person's everyday capacity to absorb or accept stress may cause PPS. This has been identified in the longer-term psychoanalytic work of McDougall (1989) in the short-term body/mind approach to psychosexual difficulties (Skrine, 1997) and in the treatment of chronic pain (Sarno, 2006; Clarke, 2007). However, the individual precipitating and perpetuating factors of their PPS may not be so obvious and require a deeper, but in my experience, not necessarily long-term exploration. The power in exploring these factors is observed in a psychotherapeutic approach to PPS in internal medicine (Broom, 2000), in Affective Cognitive-Behavioural Therapy (Woolfolk, Allen and Apter, 2012) and in the engagement in Psychodynamic Interpersonal Therapy (Creed et al., 2003; Guthrie, Margison and Mackay, 2004). I find that mind-body-emotion influence over PPS is substantially supported by the newer findings from psycho-neurobiological research (Hellhammer and Hellhammer, 2008).

2.6.1.iii. The influence of endocrine and immune systems

Ongoing internal stress can cause change to the individual's central nervous system (CNS), autonomic nervous system (ANS), endocrine and immune systems affecting cellular and metabolic function contributing to

the maintenance of PPS (Shoenberg, 2007; Cozolino, 2002; Watkins, 1997). With this understanding, the symptoms of physical dysfunction find clearer explanation.

In the case of early or later life unpredictable stress, there is an over-reaction of stress hormone production within the complex Hypothalamic-Pituitary-Adrenocortical Axis (HPA) (Watkins, 1997). Acute stress causes a release of cortico-steroids and catecholamines in the brain, thus fixing the memory of events linked to strong emotion. Learnt fear-related responses cause fight, flight or freeze in relation to the perceived threat. Alternatively, high vigilance for threat may be shown as high anxiety and a neuronal excitability that is caused by the release of glutamate in the hippocampal region of the brain (McEwen, 2000). McEwen on the neurobiology of stress, notes that when the threat is not so well-defined and the individual perceives that there is nothing clear to end that threat, then a constant state of anxiety and physical hyper-excitability may persist. A chronic state of such stress, even below conscious awareness, can lead to physical dysfunction unresponsive to routine medical care.

The findings from the different medical and psychological specialties underpin an understanding of the impact of internal stresses or conflicts, whether acknowledged and known or not yet recognized. Susceptibility to inflammation, hyperarousal and reduced capacity to fight infection through the raised levels of stress-related hormones released as a natural response to perceived threat, into the body are better appreciated. That although now medically explained, PPS eventually seem to benefit from a non-medical intervention that can address the physical and emotional impact of a natural threat response.

2.6.1.iv. Bringing into consciousness

The writings of Winnicott (1989), 1896-1971, who was both a paediatrician and a psychoanalyst, suggested that material relating to the PPS is initially found below the level of conscious awareness. Following the principle, in

practice, I routinely explore with the individual when the symptoms first started and remain alert to the emergence of any hidden stressor, allowing any related feelings to be acknowledged and understood. In many ways the process or the full mechanism of change through therapy remains a mystery both to myself and more particularly to the individual. The purpose of the abductive analysis of therapy process and outcome proposed is to deepen the knowledge of what may be happening in this practice setting.

Additinally, during this research process my view of practice has broadened in appreciation of other therapy modalities. As found in Chapter 1, empirically supported common factors of therapeutic interventions are now well-established (Cooper, 2008). This opened up a view that effective therapies for PPS interventions may also hold elements in common (see the Focused Realist Literature Synthesis, Chapter 4). Thus, a development of deeper knowledge regarding patient-therapist engagement with PPS through the realist service evaluation enables context, process and outcome to be viewed with greater clarity, taking the therapist-evaluator beyond a partisan view.

2.6.2. Ethical parameters

The ethical considerations relating to the therapist-evaluator role are considerable. Keeping this in view, attempts shall be made, through the process of this realist service evaluation design (see Methods, Chapter 5), to reduce the negative impact of this dual role, set against the advantage of exploring how the therapist and patient engage in the live therapy setting with respect to PPS. Psychotherapist Thomas-Anttila (2015) makes critical observation on the risks and benefits of the therapist as researcher of personal therapeutic engagement with the patient in therapy. She questions on this count, the ethical nature of whether a truly ‘fully informed consent’ can be a reality. Thomas-Anttila (ibid.,2015) reflects on past and more recent types of CPP process-findings and dissemination with the aim of improving practice and public awareness and finds that for

therapist and patient, this can have unexpected consequences. Maintaining patient privacy, autonomy and minimising harm to the individual when it comes to gaining patient consent and later publication of sensitive material, is found to have no fixed ethical solution. This conclusion is confirmed in Saunders, Kitzinger and Kitzinger's (2015a) & b) research on sensitive subjects, relating to anonymisation of interview data. This requires careful judgment on each case, suggesting the need for compromise in practice, acknowledging the tensions and the reality of being able to guarantee 100% anonymity. This issue is further debated in Methods, Chapter 5. The T-E shall keep in mind professional ethical guidelines in order to minimise harm at each stage of the evaluation process, particularly in the light of the contribution of sensitive personal data.

The British Association for Counselling and Psychotherapy (BACP), Ethical Guidelines for Researching Counselling and Psychotherapy (Bond, BACP, 2004) are seen at Table 2.i). These guidelines (Bond, 2004) respond to the Nuremberg Code of 1949 to ensure that the investigation does not override the needs and wishes of the patient, that the benefits and risks are addressed, and freedom to withdraw data is protected. The T-E is alerted to the potential of coercion and bias of the T-E role. The evaluation design shall aim to ensure that as far as possible, no harm is precipitated to both the individual and the therapist-evaluator during the evaluation process and communication of its findings. These ethical guidelines shall be followed and facilitated by risk assessment in each case and a consideration of transference in taking consent, by clinical and academic supervision, validated measures of change and the application of the reflexive function throughout (2.7). Ethical aspects are further addressed in the Methods study protocol (Chapter 5).

Table 2.i) The British Association for Counselling and Psychotherapy Ethical Guidelines for Researching Counselling and Psychotherapy (Bond, BACP, 2004)

Ethical orientation	Ensuring that the research or evaluation is consistent with trustworthiness in the practice of counselling and psychotherapy
Risk	Risk assessment of: potential harm to participants and adequate protection, adequate consultation on risk prior to starting and throughout the research
Relationship with participants	Obtaining consent, right to withdraw data without affecting therapy, maintaining confidentiality, taking account of participant vulnerability where the investigator is also provider of services to the participant, ensuring respect and cultural sensitivity
Research integrity	Ensuring fairness and honesty in collection and data analysis, communicating new knowledge effectively to the appropriate audience, being competent to undertake the investigation, developing constructive relationships with other investigators, taking care of own needs for personal safety and ethical treatment as an investigator, making prompt responses to any complaints
Research governance	Conscientiously considering any research or evaluation governance requirements applicable to the study

Nevertheless, Drake and Heath (2010) and Murray and Lawrence's (2000) guidance supports the ethical advantage held by the insider-evaluator's insider position on this project.

In the instance of the current study the T-E:

- is registered as a senior accredited counsellor/psychotherapist with the British Association of Counselling and Psychotherapy (BACP) and abides by the BACP (2013) Ethical Framework
- is known, trusted and professionally accountable for the quality of healthcare delivered, and is also bound by the Nursing and Midwifery Council (NMC) Codes of Conduct to work at all times in the best interests of the patient

2.6.3. Risk Assessment

The current research and evaluation requires a balance of the value of making known what happens in CPP practice against patient confidentiality, autonomy and harm reduction researched by Levine and Stagno (2001) and shall be used to inform methods (Chapter 5). Also, the balance between the willingness of participants to consent to help to improve the quality of interventions for others must be balanced with an awareness of transference issues as the therapist attempts to facilitate a 'fully informed' consent. As shown (Table 2.i.), Bond (2004) provides a summary of key ethical issues to be addressed within counselling and psychotherapy research. The evaluation design is informed by the need to reduce risk of harm through the distortion of the therapy because of patient and therapist involvement in the evaluation process, and to minimise bias in the treatment of the results by the T-E (Fig. 5.1. Process of taking consent).

The research shall factor in tools to reduce inherent bias in routine data production and collection and shall include regular professional clinical supervision of a minimum of one and a half hours on a monthly basis by an external supervisor (BACP, 2016) to assess risk to patients or to the researcher's usual care intervention. Additionally, to monitor quality and consistency, a consultation process shall be conducted during data analysis to ensure validity, and an audit of the process for developing the

results of the evaluation. In this duty of care, the investigator is required to develop the evaluation design to match the ethical issues generated by it. The methods used to ensure quality and consistency in data collection and analysis reducing the risk of harm and inherent bias, are found in Methods (Chapter 5).

Further transparency is facilitated by an explanation of theoretical terms so that these terms can be understood in particular by therapists of the main therapy training modalities and in general by commissioners and providers of healthcare services (Appendix 2). These processes help clarify the use of theory to formulate evidence and empirical evidence to build principles in the development of a cross modality conception for practice. Thus enabling an informed reader to be able to judge the truthfulness of the findings of an engagement with PPS in practice and its applicability to their own practice. Moreover, the need for a reflexive account of the therapy process and outcomes, and on the evaluation process itself, are suggested as methodologically integral.

2.7. Reflexivity

The researcher who acknowledges and discusses his or her perspectives that have influenced the design, the analysis and the findings enhances the credibility of the researcher and his or her findings (McLeod, 1994). Hardy, Phillips and Clegg (2001), support this in their appreciation of reflexivity in organisational and management theory. This makes clear the value of exposing to the reader how a research process moves forward and reveals the influences on the research outcomes.

A therapist-evaluator role requires to value the reflection of ‘in and on action’ as seminally explored by Schon (1983; 1987). Thus, the professional requirements for reflection and case supervision, as with all Counsellors, Psychotherapists and Counselling Psychologists (CPPs), is essential. In the real practice settings, this takes place internally during

and immediately after the therapy session and externally through the reflexive process of clinical supervision at a later date. This is in accordance with British Association of Counselling and Psychotherapy (BACP, 2016) and the College of Sex and Relationship Therapy (COSRT, 2014) guidelines for clinical supervision.

2.7.1. Reflexive case supervision standards

All Counselling and Psychotherapy regulatory bodies in the UK, inclusive of the British Association for Counselling and Psychotherapy (BACP), the United Kingdom Council for Psychotherapy (UKCP) and College of Sex and Relationship Therapists (COSRT) ensure that their memberships engage with a clinical supervisor on a regular basis. The subjective response of therapist to client, when examined in confidence, can be used to acquire insights into the client-therapist relationship, and used to inform the next stage of client work. At the same time, the organisational setting of the intervention and the impact of work-related environmental stresses can influence the quality of work with patients/clients and this is also considered within supervision of therapy practice.

During the evaluation, routine case supervision shall continue so that the clinical supervisor shall observe for any negligence or irregularity in the form of unusual practice events or change in attitude or approach to the patient during the course of the service evaluation and beyond. Following a discussion and mutual agreement, although the supervisor knew that an evaluation research was being undertaken, she was blind as to specifically which cases, brought into supervision for reflection, were participants. The need for protected space to undertake a reflexive cycle, making Schön's (1987) concept of tacit decision-making transparent or 'known' is, in this way, facilitated by this process.

2.7.2. The reflexive function for clinical and research practice

Schön (1983; 1987) in his philosophical studies on the process of learning considers the artistry of applying practical wisdom and gives value to the use of metaphor and image in reflecting on practice. Schön (1983) also underpins the value of making the tacit knowing developed through practice experiences explicit and therefore valued and accessible for further learning. In effect, for the sake or transparency all researchers would do well to include a reflexive approach to making known their personal research and practice perspectives both at the outset and during the analytic stages.

Qualitative research writers agree that reflexivity becomes the 'after the event' process of applying further thought and imagination to the experience (Etherington, 2004; Stiles, 1993; Schön, 1987). Etherington (2004) is a narrative researcher who draws on feminist theory to develop ways of knowing. She suggests that reflexivity supports the much needed bridge between research and practice, between the dualism of 'objective' and 'subjective' knowledge and in restoring the value of the 'rational' partnering with the 'emotional' in decision making (ibid., 2004). It is noteworthy that Etherington considers the process of reflection to be begun by conscious, purposeful thought about an occurrence and by this, influences become conscious, known and shared, rather than being perceived solely through an individual's subjective feeling.

Reflexivity shall be used in multiple structured ways throughout the study as mentioned above by:

- reflexively laying bare the pre-conceptions of the T-E
- initial reflection as therapist after each therapy session
- engaging in the reflexive process to inform subsequent therapy sessions

- using the reflexive process as T-E within regular academic supervisions and subsequent data analytic stages

Thus, it is important for this research project to find a systematic but simple vehicle for reflection, which shall not be used for mechanistic practice but for developing further knowledge. It must be simple to use and should be able to guide subsequent action.

2.7.3. Adopting a model of reflexivity

The study develops an account of the process of data generation and the development of qualitative and quantitative findings of a Realist Evaluation. Herein, it is important from the outset, in reference to ontological and epistemological perspectives, to make known to self and to others the influences that lead to the choice of methodology, data collection methods or a particular analysis of findings. The referencing of those points of decision-making through reflection 'in' experience and reflexivity 'on' experiences and to wider personal influences allows the research process to be made clear and accessible to others.

The work of Driscoll (2001/2007) in formulating the practice of clinical supervision in healthcare, identifies the use of key headings to capture the components from reflection on action through to learning and change. Borton (1970, cited in Driscoll, 2007, p.43) is evidenced as previously using the headings 'What, So What and Now What' in a schools' curriculum development project. Jasper (2003) takes these headings, arguing they are an accessible practical guide for novice healthcare practitioners to reflect on their practice from the outset. The simply headed cycle is further taken up by developers of practical guidance for clinical supervision across the caring professions (Bond and Holland, 1998) and by Rolfe, Freshwater and Jasper (2001) for nursing praxis.

Driscoll's (2001/2007) fleshing out of Borton's use of 'What, So What, Now What', is further established by Rolfe et al., (2001) and enhanced by Freshwater and Rolfe, (2001) for critical reflexivity. Due to its simplicity of

structure it was found applicable to any of the complex activities that require a reflexive account of the dilemma, processes involved and subsequent actions taken (Fig. 2.2).

The advanced Driscoll (2001/2007) sometimes known as Rolfe's Reflexive Cycle is shown at Figure 2.2.

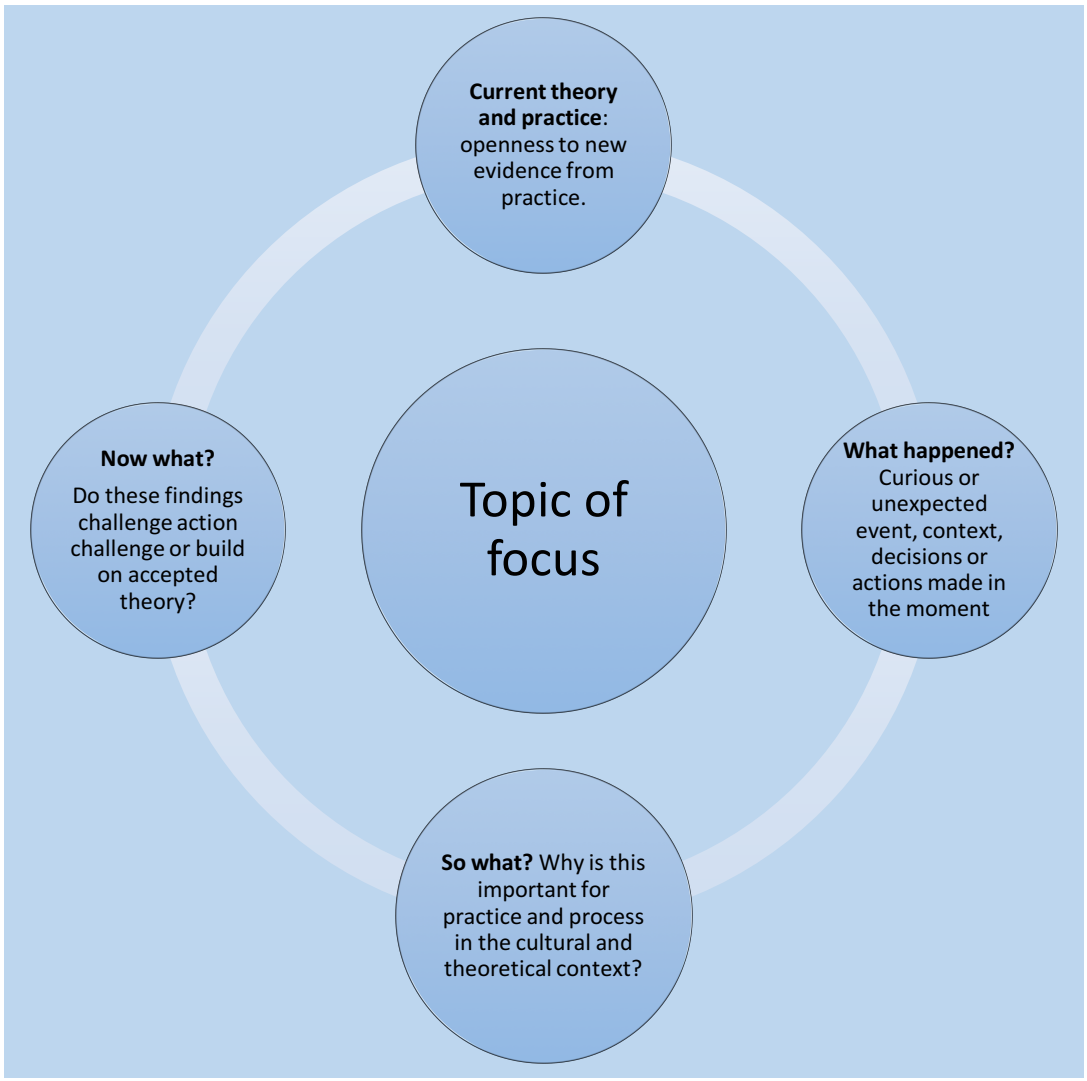

Fig. 2.2 Reflexive cycle headings: What? So what? Now what?
(after Driscoll (2001) and Freshwater and Rolfe (2001)

This type of structure carries and makes known the process of reflexivity in all areas that require reflection within this insider Realist Service Evaluation.

Moreover, Freshwater and Rolfe (2001) have built on the concept of reflexivity as outlined by Schön (1983; 1987) whose work is mentioned above. Thus, for these nursing researchers, a reflexive process can be in play, not just after the event but when change is effected whilst in practice, this can, they suggest, be recognised as reflexivity in action. Freshwater and Rolfe adopt the conceptualisation of reflexivity as three fairly distinct processes or types. All of these processes develop and demonstrate the individual's contextual awareness and openness to change (see Table 2.ii).

Table 2.ii) Types of reflexivity after Freshwater and Rolfe (2001)

Type of reflexivity	Parameters of reflexivity
Type I	An after event reflection on the process of reflection on an experience, decision or event to deepen a personal awareness of self and what happened in the moment.
Type II	Considers the wider context of the experience, decision or event embracing context, culture and theory.
Type III	Practical reflection in action that leads to a change in response there and then.

Theory, although indicating probability for a majority, underdetermines day to day interventions with individuals and therefore cannot in itself bridge

the theory-practice gap. Freshwater and Rolfe's types of reflexivity (Table 2.ii) illustrate a means of capturing the concept of 'phronesis' as previously discussed and setting it in context. The work of Benner (1984) and Usher and Bryant (1989) underpin the value of laying bare how clinical decisions are made in action and the benefits of making conscious these processes to allow them to be valued and known by others.

Schön (1987) further raises the issue of closing the research-practice gap full circle. This feeds into realist evaluation as he argues that the value of findings developed through a process of reflection in and on practice can be compared to current theories. The reflective practice highlights the process as to how these theories are adapted locally to the needs and context of the real world moment. In this way, reflective practice is used to enhance the theory, which is subsequently tested and further refined in day-to-day practice. The practitioner builds up a series of case examples which result in the growth of clinical competence (Schön, 1987). Thus, the reflexivity as outlined by Freshwater and Rolfe (Table 2.ii.) can inform and act as another means of making known 'how' the patient and therapist engage with persistent physical symptoms. Also, this brings in increased transparency in analytic decision-making and the validation of data. Thus Freshwater and Rolfe's way of thinking about the value of reflexivity and its function, underpinned by the work of Schön, shall be included in the therapist-evaluator (T-E) role.

2.8 Summary

This chapter has provided a critical examination of the ways in which knowledge is developed and becomes accessible to clinical practitioners. Also, the value of building Practice-Based Evidence, in particular for understanding counselling and psychotherapy process has been recognised as key to finding what works in the unpredictable world of every-day practice. Moreover, the requirements of the T-E's NHS Professional Doctorate sponsor, Cambridgeshire Community Services,

determined that the project should aim to enhance the quality of care and service provision. This led to the decision of exploring the ontology and epistemology underpinning a realist service evaluation of current practice.

Additionally, particularly in the light of researching sensitive material and the T-E's psychotherapeutic practice in action, the ethical considerations for the reduction of harm to participants shall be further considered in detail in the Methods (Chapter 5). Author reflexivity, using Driscoll's (2001) reflexive cycle enhanced by Freshwater and Rolfe (2001) has been argued as an essential methodological component of the evaluation design facilitating the need for micro-ethical judgments in practice to be made, as discussed by Guillemin and Gillam (2004), transparently. Thus, the enhancement of current theories and evidence-based practice for engagement with persistent physical symptoms, despite its complexities, can now be ethically underpinned by a reflexive insider-Realist Service Evaluation (ri-RSE) methodology. The following chapter opens the door to this adventure and gives account of a broad and underpinning realist synthesis of the literature concerning the challenges to engaging with persistent physical symptoms in healthcare.

Chapter 3: A Realist Wide-Scoping of the Literature

In Chapter 1 an initial outline and preliminary justification of this study was given set within the local evidence and experience of personal clinical practice. Cognitive Behavioural Therapy (CBT) and Short-term Psychodynamic Psychotherapy (STPP) are used by a simple definition of counselling and psychotherapy as particular therapy modality examples that are relevant to this study. Also, the common factors across therapy modalities, which are now well established by research findings (Wampold and Imel, 2015; Cooper, 2008) were explored. Chapter 2, indicates realist service evaluation (RSE) as a responsive framework, within which a particular service intervention for persistent physical (sexual) symptoms within a primary, community healthcare setting should be studied.

The findings of the initial broad realist literature synthesis of this chapter, (literature review from 1990 to 2014) are underpinned by the realist perspective found in the previous chapter (2.4.). This chapter steps beyond the assumptions of the Cochrane standard systematic literature review to embrace wider sources as guided by Greenhalgh et al., (2011). This chapter further meets Aim 1 of the evaluation (1.1.) to reveal the contextual challenges of addressing PPS in healthcare.

3.1. Planned realist wide-scoping of the literature

An initial wide scoping of the literature was undertaken, with literature taken into account between 1990 to 2014. This was intended to take a broad view of the PPS phenomenon in healthcare settings following RAMESES quality standards for realist literature synthesis by Wong et al., (2013). Despite the critique of the name ‘Medically Unexplained Symptoms’ (MUS) within the publications, the term MUS along with

‘somatisation’ and ‘somatization’ opened the door to finding key literature search terms (Royal College of Psychiatrists, RC Psych, 2009).

During the literature review, the Medline database was found to be set up in the 1950s to include medical, medical psychology and advanced nursing practice research material from around the world. A mapping of the keyword ‘Medically Unexplained Symptoms’ (MUS) to thesaurus within MEDLINE showed a list of terms beginning with Somatoform Disorders (SD). The scope note read as follows:

> Disorders having the presence of physical symptoms that suggest a general medical condition, but that are not fully explained by a general medical condition, by the direct effects of a substance, or by another mental disorder. The symptoms must cause significant distress or impairment in social, occupational, or other areas of functioning...the physical symptoms are not under voluntary control.
>
> (MEDLINE accessed August 2010)

The list of search terms included ‘Somatis(z)ation Disorders’.

3.1.1. Parameters for initial wide-scoping of the literature

The wide scoping, which served to underpin the detailed realist literature synthesis of Chapter 4, began with a search within the published literature over the previous twenty years, from 1990-2010. This was updated to December 2014. The search terms found in systematic reviews were used to define the inclusions in order to examine the phenomenon of adult PPS in healthcare settings.

Inclusions:

- 1990-2014
- Adult 18-64
- All languages
- ‘Somatoform Disorders’
- ‘Medically Unexplained Symptoms’

- ‘Hypochondriasis’
- Somat*, somatization, somatization
- ‘Psychosomatic disorders’
- ‘Primary care’, ‘primary healthcare’, ’out-patient’, ‘in-patient’
- therapy, treatment, intervention

The exclusions for the wide-scoping were of published studies focusing on complex comorbidity, disease or aged-based physical symptoms treated by medication alone.

Exclusions :

- Personality Disorder
- Substance Addiction
- Medication only interventions
- Eating Disorders
- Psychoses
- Dementia

The literature sampling strategy for the wide-scoping included papers from peer-reviewed journals and a comprehensive search across the following databases: Cochrane Library Database of Systematic Reviews, Database of Abstracts of Reviews of Effects (DARE), Health Technology Assessment database (HTA), NHS Economic Evaluation Database (NHS EED), Allied and Complementary Medicine Database (AMED), British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL), EMBASE (Journal and conference coverage on bio-medical issues, wider than Medline), Health Management Information Consortium (HMIC), Medical Literature and Analysis and Retrieval System MEDLINE, PsycINFO (database of abstracts of psychological research).

For a detailed literature review, the realist plan included contacting experts in the field to provide further direction to find material and access to unpublished material. Also, an examination of the classification systems ICD-10 and Diagnostic Statistical Manual of Mental Disorders (DSM-IV,

APA, 2000) and DSM-5 (APA 2013a) was planned to discover more about the complexity of the PPS phenomenon. Additionally, an examination of treatment-guides and trainings for medical, nursing, counselling and psychotherapy in relation to PPS was planned to find out what was happening in the real world of clinical practice. To achieve this, the following professional bodies were contacted by email and telephone and website review for training to address PPS in clinical caseloads:

- British Association for Counselling and Psychotherapy
- British Association of Psychotherapists
- National Website for the Improving Access to Psychological Therapies programme
- National Institute of Clinical Excellence, UK
- Royal College of Nursing, UK
- Royal College of Psychiatrists, UK

Additionally, theses held in the British Library Database of Theses were searched for further reference links. Finally, conference abstracts were examined for professional contacts and content. Also whenever and wherever possible conferences on PPS in the period between 2010-2014 were attended.

The abstracts of 279 articles were examined with 146 full text papers forming this wide scope. The literature and information from professional bodies (or lack of it) illuminated the medico-cultural setting in which attempts have been made to address the phenomenon of PPS. This indicated that it is required to overcome multiple hurdles effectively to address PPS sufferers, who frequently approach GPs for help. The descriptive findings of the realist wide scoping are categorized and described under the various headings as discussed below. These thematically conceptualised headings show complexity and challenge in the delivery of interventions within healthcare settings for this patient group and lack of skills training for professionals.

3.2. Debate regarding classification of PPS

When this study began, the Diagnostic Statistical Manual of Mental Health Disorders-IV (APA, 2000) and the International Classification of Diseases (ICD-10) (WHO, 1994) used the term 'Somatoform Disorders' (SDs) to identify those physical signs of ill health or dysfunction that were not responding to medical intervention. But this terminology was insufficient to denote the majority of PPS sufferers that were not found to be covered by the Somatoform Disorder category and thus other terminology was developed.

3.2.1. Abridged Somatoform Disorder

Numerous researchers noted that the previous Statistical Manual of Mental Health Disorders, DSM-III, was not picking up the majority of persistent medically unexplained symptom sufferers in the population. This brought to light the fact that the incidence of the phenomenon in the general practice population was hard to calculate. Thus, in order to capture the cross-section of individuals with PPS, the term 'Abridged Somatoform Disorder', was tested and studied in primary care (Escobar et al., 1998) and then put into use. The inclusion into the "abridged" definition of somatoform disorders took four persistent physical symptoms for men and six for women.

3.2.2. Undifferentiated Somatoform Disorder

The Escobar et al., (1998) research showed that one fifth (ie. 20%) of the general primary care population can be categorized within the parameters of Abridged Somatoform Disorder (3.2.1.). In a study of 206 patients with Medically Unexplained Symptoms (MUS), Smith et al., (2005) found that only 23% of the cohort with were DSM-IV somatoform positive whilst the remainder fell outside. The authors argued that the term 'Undifferentiated Somatoform Disorder' (USD) could embrace this population. The term USD was critiqued by a number of authors to be too inclusive for research purposes (De Waal et al., 2004) and the term 'Abridged Somatoform

Disorders' (Escobar and Gara, 1999) was utilised more often for research studies. This inevitably led to differing estimations of incidence, disagreement amongst researchers and confusion in diagnosis for primary care physicians (Martin, 1999; Escobar et al., 1987; Smith, et al., 2005). The DSM terms were critiqued by major professional bodies such as the UK Royal College of Psychiatrists and GPs (2009) for their inadequate attempts to classify PPS.

Despite the extensive debate about classification at the time, Olde Hartman et al., (2008) reported that at general practice level, knowledge of the subject remained poor. Henningsen and Creed (2009) in a draft paper of a psychiatry liaison MUS/PPS study group, confirmed that General Practitioners (GPs) were unlikely to use the classifications at the time proposed by ICD-10 and DSM-IV. The research agenda for MUS in family medicine through the world conference, WONCA 2007, re-iterated the need for a broadly accepted definition of Medically Unexplained Symptoms and a strategy to recognize MUS more readily (Olde Hartman et al., 2008).

3.2.3 Functional Somatic Syndromes

Individual patients who present with particular groups of persistent symptoms, such as Irritable Bowel Syndrome or Atypical Facial Pain (Table 3.i), were previously identified under 'Functional Somatic Syndrome' (FSS) (see Appendix 2) within the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (APA, DSM-IV, Axis III Medical Conditions). Functional Somatic Symptoms (FSS), is the term used for clusters of symptoms, which in the past were linked to the Somatoform Disorder (SD) phenomenon. Additionally, with the newer 'Somatic Symptom Disorder' (SSD) of DSM-5 (APA, 2013) only applying to the smallest percentage of the most severely affected with PPS (3.2.4.), the diagnosis and classification of FSS is still being hotly debated as to whether it should be linked to Somatoform Disorders. SSD is characterised by overt rumination and anxiety over the symptoms.

Examples of Functional Somatic Symptoms are given by medical speciality (see Table 3.i).

Table 3.i) Examples of Functional Somatic Syndromes by medical speciality

Medical Speciality	Functional Somatic Syndrome
Dentistry	Atypical Facial Pain Temporomandibular Joint Dysfunction
Respiratory Medicine	Hyperventilation Syndrome
Rheumatology	Fibromyalgia Repetitive Strain Injury
Cardiology	Non-Cardiac Chest Pain
Gastroenterology	Aerophagia, Dysphagia, Heartburn, Chronic Nausea/Vomiting, Dyspepsia, Irritable Bowel Syndrome, Bloating, Constipation, Diarrhoea, Abdominal Pain, Chronic Proctalgia, Defaecation Disorders
Neurology	Tension-type headache, dizziness, loss of sensation, non-epileptic seizures
Ear, Nose and Throat	Globus Syndrome (difficulty in swallowing)
Infectious Disease	Chronic Fatigue Syndrome, Myalgic-encephalomyelitis
Non-allied syndromes	Gulf War Syndrome Chronic Whiplash Candidiasis Hypersensitivity Multiple Chemical Sensitivity

(Adapted from Burton, 2013)

Despite referrals from primary physicians to secondary care specialist medical consultants for extensive investigation, for patients with FSS there is also poor understanding of causation and a consequent struggle to find medical solutions for the relief of ongoing or persistent manifestations of FSS.

3.2.4. Somatic Symptom Disorder

The most recent diagnostic parameters of DSM-5's 'Somatic Symptom Disorder' (SSD) (APA, 2013) (see Table 3.ii) support its users in its clarity of definition. In these diagnostic parameters, diagnosis is not done by an absence of medical explanation. But diagnosis is based on one or more distressing or life disrupting physical symptoms of longer than six-month duration, are linked with excessive time spent in anxious anticipation of worsening health and registered as mild, moderate or severe. DSM-5 comments that, '…somatic presentations can be viewed as expressions of personal suffering inserted in a cultural and social context.' (APA, 2013) p.310). However, excessive rumination and anxious energy spent over their symptoms with 'disproportionate' concern is found only in the 5-7 % of the PPS population (APA, DSM-5, 2013, p. 312). This level of individual concern as suggested by the SSD criteria, is an essential aspect of the diagnosis. In effect the new Somatic Symptom Disorder (SSD) diagnosis now excludes all but the extreme-end PPS presentations in healthcare, representing under 10% of the total PPS population (RC Psych., 2009). The Somatic Symptom Disorder criteria are presented in Table 3.ii).

Table 3.ii) Diagnostic criteria DSM-5 'Somatic Symptom Disorder' (SSD) after APA (May 2013)

Patient presentation: **To meet criteria for SSD, criteria A,B & C are necessary**	**Requirements for the definition of SSD**
A. Somatic symptoms	One or more somatic symptoms that are distressing and/or result in significant disruption in daily life
B. Excessive thoughts, feelings and behaviours related to these somatic symptoms or associated health concerns	At least one of the following is required to meet this criterion: (1) High level of health related anxiety (2) Disproportionate and persistent concerns about the medical seriousness of one's symptoms (3) Excessive time and energy devoted to these symptoms or health concerns
C. Chronicity	Although any one symptom may not be continuously present, the state of being symptomatic is chronic (at least six months)
If predominant pain	Previously known as pain disorder
If persistent	Characterised by severe symptoms, marked impairment, and long duration (more than 6 months)
Current severity	Mild: Only one of the symptoms in Criterion B Moderate: Two or more of the symptoms in B Severe: Two or more of the symptoms in B plus multiple somatic complaints (or one very severe somatic symptom)

3.2.5. Bodily Distress/Stress Disorder

Further attempts to avoid the difficulty for patients of applying a mental health diagnosis to individuals with PPS, noted by Creed and Guthrie (1993) and Salmon, Peters and Stanley (1999) and by Aiargzaguena et al., (2008), have been made by Schroder and Fink (2010). Fink, Toft, Hansen, Ornbol and Olesen (2007) undertook a study of bodily distress in 978 individuals in internal medicine, neurology and primary care settings and began to formulate their empirically derived criteria for Bodily Distress Syndrome (BDS). This outlined ten diagnostic categories of Functional Somatic Syndromes and Somatoform Disorders with no mention of mental health categorisation (see Table 3.iii). It is noteworthy that the BDS grid does not include persistent sexual symptoms that are 'not wholly explained by medical condition' as found in the therapist-evaluator's naturalistic practice.

Table 3.iii) Diagnostic criteria for Bodily Distress Syndrome (BDS) after Fink et al., 2007

Does the patient have the following?		Symptom Groups
YES	NO	≥3 cardio-pulmonary/autonomic arousal Palpitations, heart-pounding, precordial discomfort, breathlessness without exertion, hyperventilation, hot or cold sweats, dry mouth, churning in stomach/'butterflies', flushing or blushing
		≥3 gastro-intestinal arousal Abdominal pains, frequent loose bowel movements, feeling bloated/full of gas/distended, regurgitations, constipation, diarrhoea, nausea, vomiting, burning sensation in chest or epigastrium
		≥3 musculoskeletal tension Pains in arms or legs, muscular aches or pains, pains in the joints, feelings of paresis or localized weakness, back ache or pain moving from one place to another, unpleasant numbness or tingling sensations
		≥3 general symptoms Concentration difficulties, impairment of memory, excessive fatigue, headache, dizziness
		≥4 symptoms of the above groups

Dissatisfaction with classification was found to be a central theme in the literature along with a call for improved diagnostics of 'Medically Unexplained Symptoms' (MUS) as DSM-5 was being developed (Burbaum et al., 2010; Pols and Battersby, 2008; Morriss et al., 2010; Larisch, Fisch, and Fritzsche, 2005; Walters et al., 2007). The definition of Somatic Symptom Disorder (DSM, 2013) is very much simplified. It takes account of the parameters of Bodily Distress Syndrome but the local patient cohort with persistent 'medically unexplained' sexual symptoms, 'not wholly

explained by medical condition/not elsewhere specified', remain unrepresented.

As stated earlier those individuals that were previously identified by the terms 'Abridged Somatoform Disorder' and 'Undifferentiated Somatoform Disorder', no longer fall into the 'Somatic Symptom and Related Disorders' mental health category of DSM-5, which will be perceived by many sufferers as helpful. But with new categorization, they are now at risk of falling from the attention of researchers. However, ICD-11 preparations suggest that the inclusion of Bodily Distress Disorder with Somatic Symptom Disorder leads to retaining them under mental health diagnoses.

The earlier key study of medical out-patients presenting with PPS in two London Hospitals (Nimnuan et al., 2001) defined by the term 'Undifferentiated Somatoform Disorder' of the DSM-IV, reveals the continued health burden to individuals and healthcare providers of those with persistent physical symptoms (PPS) of longer than six-month duration (see Table 3.iv). This indication of health burden aligns with previous findings from Nimnuan et al., which using the alternative International Classification system (ICD-10), stated that 'symptoms and signs of ill-defined conditions' is the largest category of NHS hospital out-patient expenditure. Individuals suffering from PPS of 'unknown' origin, in this instance, do not appear to be effectively served by a continued lack of agreement of terms for this middle range group of 'mild to moderate' and on occasions severe but non-ruminating physical symptom sufferers.

3.3. Predisposing factors

The challenges of treating physical symptoms that do not respond to the medical model of intervention have led to research into the predisposing factors. Brown (2004) undertook a critical discussion of the psychological mechanisms of PPS and argued for an integrative conceptual model based on cognitive psychology. Brown critiques the early psychoanalytic

concept of ‘conversion’ caused by the repression of unacceptable events and emotions as developed by Breuer and Freud (1895/1991). Their early observations led to the concept of dissociation from underlying trauma or conflict. Wessely (2001) is cited by Brown to warn against the dangers of ‘relentlessly probing for forgotten material’. Brown suggests that the formulation of a treatment for PPS based on the assumption of underlying conflict, ‘may be both misleading and potentially damaging’ (2004, p. 798). Moreover, he makes little mention of the role of emotion in the perpetuation of persistent physical symptoms.

Nevertheless, the term ‘somatisation’ as an experience of psychological distress follows this early work of Breuer and Freud and is captured by the work of Lipowski (1968) who embraced the normality of physical responses embedded in the particular psychosocial environment. Additionally, Kirmeyer and Taillefer (1997) argue that normal physiological responses are interpreted as illness and become catastrophised through illness worry, previous experience of illness in self or illness patterns of close relatives creating further stress-related physical symptoms. However, their model of the development of ‘somatoform disorders’ does not fully embrace the majority of non-ruminated PPS. Mobini (2015) of the Institute of Cognitive Neuroscience, University College London undertakes a practical review on the psychology of PPS, giving examples of contributing factors, arguing nevertheless, that not all those with predisposing factors go on to develop PPS.

Persistent Physical Symptoms have been linked with attachment difficulties that one would develop in childhood (Wilkinson, 2010; Meredith, Ownsworth and Strong, 2008). PPS has been found influenced by early life carers with PPS themselves (Taylor and Asmundson, 2004) and with sexual abuse in childhood (Sharpe and Faye, 2006). In adulthood PPS shows links with low social support (Nakao, Tamiya and Yano, 2005), depression and anxiety (Lieb, Meiniscmidt and Araya, 2007) and hypervigilance to physical changes (Wilhelmsen, 2000).

Moreover, Mobini discusses the work of Johnson (2008) who draws together recent neuro and immunobiological research to be illustrative of predisposed and current life stresses as perpetuating factors of PPS. A number of physiological responses to stress contributing to PPS are listed below:

- the stress-response as an overstimulation of the hypothalamic-pituitary-adrenal axis causes a dysregulation of cortisol
- visceral (gut) hypersensitivity
- neuronal sensitisation and hyperexcitability
- autonomic dysregulation
- immune suppression

Mobini (2015) proposes that the predisposing factors are exacerbated by the biological responses to stress, the latter as a consequence of personal psychosocial stressors and interpersonal conflicts, finding that research on PPS treatment is still in its early stages. There is a concluding recommendation for a more integrated treatment approach that would embrace the precipitating and perpetuating biological, psychological and social factors of PPS.

3.4. Incidence in healthcare consultations

The planned cyclical and iterative wide realist literature search further revealed that the incidence and routine healthcare provision for people suffering with long-term physical symptoms do not recover spontaneously or with medical care alone. In a study of two London Hospitals' out-patient clinics, the number of individuals with PPS, looking for diagnosis and treatment recommendation has been estimated to be between 20%-35% daily in primary care (Fink et al., 1999; De Waal et al., 2004). Also, of those attending the secondary specialist medical consultations, as many as 37-66% were found to have PPS (Nimnuan et al., 2001) that was untreatable within the medical specialism to which they were referred. It is

seen that the numbers of individuals seeking improved health through primary and secondary healthcare consultations for PPS is substantial (Table 3.iv).

Table 3.iv) Prevalence of Medically Unexplained Symptoms in Hospital Out-patient Clinics in two London Hospitals (Nimnuan et al., 2001)

Hospital Out-patient Clinics:	Prevalence of Medically Unexplained Symptoms (MUS)
Dental	37%
Chest	41%
Rheumatology	45%
Cardiology	53%
Gastroenterology	58%
Neurology	62%
Gynaecology	66%
Total mean:	52%

As confirmation of the findings of the King's College Hospital, London study (Nimnuan et al., 2001), PPS researcher Barsky found that somatization increases medical utilisation and costs independent of psychiatric or medical co-morbidity. Twice as much health care utilisation as those non-somatising was discovered (Barsky, Orav and Bates, 2006).

3.4.1. A world-wide phenomenon

The so-called phenomenon of persistent 'medically unexplained' physical symptoms (PPS), that do not get better over the passage of time or by medical intervention is not confined to western societies only. There is a representative research concerning the incidence and complexity of medically unexplained symptoms that reveals it to be present world-wide (Husain et al., 2011; Sumathipala et al., 2008).

The published literature is indicative of the international concern in attempts to find the causes and effective treatment strategies for this patient group. Also, the challenge to develop effective healthcare delivery, as found by Gureje et al., (1997) in a World Health Organisation primary care study, continues to be reflected in more recent studies. Natsov and Hranov (2011) studied the incidence of somatisation in primary care in Bulgaria and found a 35.5% incidence of individuals with more than three PPS, but only 3.7% fell into the DSM-IV Somatoform Disorder diagnosis of the time.

Moreover, the authors urge early detection to avoid unnecessarily frequent medical investigations that may prolong the PPS experience. This is reaffirmed by the University Hospital, Ghent in an account of a multidisciplinary care network for people from East and West Flanders in the early phase of PPS presentation without obvious disease and for those (fewer in number) with long-term symptoms such as Chronic Fatigue Syndrome (CFS). The authors Tobback et al., (2014) re-iterate the value of primary care physicians in playing a key role for identification and timely referral for further psychosocial interventions that can, they suggest, avoid the ill-health of longer term persistent physical symptoms.

3.4.2. Links to anxiety and depression

In primary care set up, the need to treat any associated or causative anxiety and depression is well recognised. In a German study of 620 consecutive patients who consulted primary care physicians using the Patient Health Somatic Symptom Questionnaire-15 (PHQ-15), Steinbrecher et al., (2011) found that over twelve months the prevalence of PPS ('somatoform disorder') was 22.0%. Of these, 43.2% were found comorbid with a mental health disorder, most commonly with anxiety or depression. Understandably, from previous evidence, the UK National Institute for Health and Care Excellence (NICE) recommends treatment for PPS linked with anxiety and depression in primary care to include talking therapies and or by medication as prescribed by their General Medical

Practitioner (GP) (Fink et al., 1999; Leiknes, Finset and Moum, 2010; NICE, 2011).

Remarkably, the realist wide-scoping reveals that the majority of PPS presentations are not necessarily linked to anxiety and depression. This finding is in opposition to the document addressing Long Term Conditions and Medically Unexplained Symptoms. Talking Therapies: a four-year plan (DH, 2011b), states that 70% of all PPS are linked to anxiety and depression (ibid., p. 21. point 73). The realist search identified a lower figure of 30-49% co-morbidity through the findings published by researchers Sattel et al., (2012) which included a randomized controlled primary study (Steinbrecher et al., 2011) of prevalence (see detail at 3.5.). Fink et al., (2007) exploratory research of 978 individuals in acute and GP settings and Nimnuan et al., (2001) within hospital out-patient clinics; all showed figures of PPS sufferers with an anxiety and depression prevalence to be below 49%. The IAPT medically unexplained symptom (MUS) positive practice guide concerning matched care referral pathways (2014) now acknowledges that not all sufferers will benefit from anxiety and depression treatment.

Research studies into PPS, which have not responded to bio-medical intervention, or that fail to recover spontaneously over time also show differences in physical manifestation and clinical presentation (Table 3.i). Results of randomised controlled research studies (RCTs) are therefore difficult to aggregate and subsequently affect the lack in treatment pathways. A study of 284 GP's perceptions of PPS found that less than 50% thought that there were effective treatments available to which to refer for PPS (Reid et al., 2001). As mentioned in the introduction, there is still indication, that despite IAPT initiatives, service delivery for this patient group is still in the early stages of development (De Lusignan, Jones et al., 2013).

3.5. The challenge beyond treating anxiety and depression

By qualitative studies (Wileman, May and Chew-Graham, 2002; Greer and Halgin, 2006; Dwamena et al., 2009), consultations with this patient group were found to be challenging with minimal access to therapies to address the phenomenon. Additionally, Primary Physician self-pressure to respond by repeated physical investigation and specialist medical referral to exclude organic causes (Ring, 2007; Salmon et al., 2007) was identified.

3.5.1. A lack of training

From studies published between 2001 and 2014, the greater percentage of PPS sufferers do not have co-morbid anxiety and depression and had no clear diagnostic definition or care pathway by which to develop better health. Despite of this, the total PPS patient population is estimated to cost the National Health Service in the UK, ten per cent of its annual budget (Bermingham et al., 2010). Also, the importance of addressing PPS effectively in practice is highlighted in service outlines such as the Improving Access to Psychological Therapies, UK positive practice guidance for addressing PPS (2008, updated 2014) and by professional bodies (Schaefert et al., 2012, Brettle, 2010; IAPT, 2014; RC Psych., 2009, CR152). However, training for healthcare professionals in positive therapeutic approaches to the patient with PPS cannot be necessarily linked to anxiety and depression. Moreover, training to address PPS was found to be patchy in medicine and hard to find in undergraduate training for nursing and generic psychological 'talking' therapies (see 3.1.1. for searched websites/organisations).

The UK government's Improved Access to Psychological Therapies (IAPT) initiative has undertaken a pilot exploration of therapists, specifically those who only relatively recently have been charged with addressing PPS linked with anxiety and depression (Richards, Farrand and Chellingsworth, 2011). Even here, the qualitative aspects of the evaluation found that the

therapists were interested in undertaking this work but felt they needed greater awareness and training regarding intervention with this physical aspect of their client's presentations (De Lusignan, Jones et al., 2013).

3.5.2. Scarcity of effective treatment pathways

The use of Cognitive Behavioural techniques (CBT), or the Extended Reattribution Model (Toft et al., 2010) delivered by frontline GPs and nurses in primary care have not yet been shown to alter health related outcomes with clinical significance (Rosendal et al., 2013). For such patients, there are a few resources within Mental Health Services in the UK to which to refer individuals with somatisation that is not necessarily linked to anxiety or depression (Creed, Henningsen and Fink, 2011). However, Mental Health Services in England are confined at this present time to addressing only the most acute mental health conditions such as psychosis and schizophrenia and as Creed et al., (ibid., 2011) identifies, mental health services rarely directly undertake interventions for Somatic Symptom Disorders. This begins to clarify why this identified patient group has been under-served within the medical model and mental health delivery of services.

Patients may remain caught in the separation of mental and physical healthcare provision being referred either to medical specialists or for non-medical 'Talking Therapies' (Bermingham et al., 2010). In this referral system, if there is no evidence of organic disease-base or mental health cause, the individual is returned again to the care of their GP. This cycle of events has been to the increasing frustration and time cost of physicians and most importantly to the continued costly distress of the individual sufferer in search of help (Fink and Rosendal, 2008; Peters et al., 2009; Kathol et al., 2010).

3.5.3. Responses to PPS sufferers within healthcare

The foundation of safe medical practice primarily involves excluding disease-based causes for physical symptom presentations that are not getting better over time. However, evidence within the PPS cohort proves that GPs are reported to order investigations and interventions far more often than clinically indicated. The qualitative study recorded by Dowrick, et al., (2004) found that of 36 patients consulting GPs, only 2 specifically asked for physical investigations, while 34 were given them. The same research team proposed that the raised level of physical intervention might lie in the premise that Primary Care Physician's felt pressure in the consultation 'to do something' rather than by direct patient request.

Salmon et al., (2007) further showed by qualitative research that patients in practice do not demand physical treatments for PPS, but the more they expand on physical symptoms, the more GPs use somatic investigation and treatment. In a Sri-Lankan study by Sumathipala and colleagues (2008) it was reiterated, that only 8.8% of the 66 patients studied, expected investigations. Also, a qualitative study of GPs perspectives on PPS in Pakistan showed similarities with European counterparts. In this study, only 34% of GPs felt that there was effective treatment for somatisation. GPs focused more on physical causes with this patient group (Husain et al., 2011). Additionally, a critical review by Kroenke and Swindle (2000) further showed that 81% of somatisation sufferers were found to be willing to undertake psychological treatment in primary care in order to help them to make sense of their intractable symptoms.

Reid et al., (2001) took a random sample in South Thames (West) region, England of 400 GPs to study GP attitudes towards the cause and management of PPS in their patients by postal questionnaire. Of the 284 replies (representing 75% return rate) it was thought that the majority of these patients had personality or psychiatric illness. In effect, this may only be the reality for a minority of the PPS group as a whole. This misconception arises not only from the lack of skills training and time for

exploring the PPS alongside the patient in primary care, but impacts the commissioning and delivery of effective services for this patient population to whom the GP can refer with confidence.

3.5.4. A place for Liaison Psychiatry

Overall, the qualitative research recommendations called for support from liaison psychiatrists to develop adequate management strategies for the most severe cases. Such guidance for General Practice has developed in one area through the innovation of The City & Hackney Primary Care Psychotherapy Consultation Service led by Consultant Clinical Psychologist Brian Rock. This service has undertaken a review of its impact in practice and provides evidence of a model of consultative support for GPs in their day-to- day care of patients with ruminated PPS, who fall within the latest and very specific Somatic Symptom Disorder classification of DSM-5 (APA, 2013). This service is described as a flexible, adaptive model meeting both the patient and his primary care physician's need for expert support and empathic exploration using psychodynamic principles. (Carrington, Rock and Stern, 2012). This is just one of a handful of Liaison Psychiatry Services that are attempting to address severe-end PPS in England and Wales.

As gate-keepers of front line healthcare, the GPs in England have been found to be both challenged and in a challenging position in relation to PPS sufferers and healthcare delivery. The primary care physician in the UK in general, embraces the bio-psychosocial model of practice, acknowledging the influence of the impact of biology, personal circumstances and psychological responses in the diagnosis and evaluation of disease processes. This realist wide-scoping of the literature suggests that the biopsychosocial model of health and illness, as applied in routine practice, appears to have failed the majority of PPS sufferers.

3.6. The context of the bio-psychosocial model

It was proposed at the time of its development that the change from a bio-medical to a biopsychosocial model of health and illness would enable greater effectiveness in medical consultations (Engel, 1977). George Engel, professor of psychiatry and medicine (1977) had argued controversially at the time, that the bio-medical model approach to disease had become a cultural 'folk model' in Western medicine. In its positivistic-approach, that is based on the division between body and mind, the bio-medical model by experimentation and research has nevertheless greatly improved survival rates and quality of life through symptom reduction for individuals with diverse diseases or age-based physical conditions.

However, Engel suggested that the bio-medical model inevitably excludes the messiness of 'social, psychological, and behavioural dimensions of illness' (1977, p. 130). Many 'hard-to-diagnose' conditions presenting in primary and secondary care were and remain, frustratingly unresponsive to medical intervention. In the past, patients who were 'hard-to-treat' were referred to the discipline of psychiatry. Psychiatrists in turn believed that disease-based conditions of the brain could be successfully eliminated once the natural cause (such as alterations in biochemistry or neuro-physiological dysfunction) were discovered and treated by medication. These psychiatrists were ill-equipped to address individuals whose condition was considered primarily linked to their difficulty in adapting to their social world, and thus, Engel reported that these patients were considered to be better taken care of by non-medical professionals at that time (Ludwig 1975, referenced by Engel, 1977, p.129).

However, the bio-psycho-social model is now well-established as an acceptable approach for the majority of medical and nursing practitioners in primary and acute-care settings. This can be attributed to the recognition of the impact of social and relationship environments and emotional responses and their influence over ill-health recovery. In the recent past GPs could engage primary care counsellors within a minimal

waiting time, to deliver interventions for individuals within their surgery setting, addressing psycho-social issues and moderate, long-term anxiety and depression difficulties and distress over serious illness diagnoses.

It is peculiar that despite the adoption of a psychosocial perspective to persistent medically unexplained physical symptoms, significant numbers of patients still with such symptoms are unable to find the compassion and understanding that they deserve (Burbaum et al., 2010; RC Psych, 2009; Olde Hartman et al., 2008). Since the inception in 2008 of the English stepped model of care relating to talking therapies, Improving Access to Psychological Therapies (IAPT, UK), this personal direct referral connection within primary care practices has been lost. Professionally accredited counsellors and psychotherapists, that are not solely reliant on CBT perspectives are in the majority, no longer employed by IAPT Wellbeing Services. These accredited professionals represent a highly skilled workforce (BACP, 2014) that is ready, with low-cost upskilling, to expand engagement with this complex phenomenon and thereby improve access to effective interventions for PPS sufferers.

The more recent psychoneurobiological research linked with endocrine and immunological systems cited in Chapter 1.2.3., clearly suggests the interlinked nature of the physical, emotional and psychological (the latter sometimes below conscious awareness), in the conception of health and illness (Watkins, 1997; Hellhammer and Hellhammer, 2008, Luyten, van Houdenhove et al.,2012; Johnson, 2008).

3.6.1. Enhancement of the bio-psycho-social model

Over the years, pockets of interesting practices have developed beyond the medical and current understanding of the bio-psychosocial model of care in an attempt to address the patient's deep underlying factors to PPS within routine professional medical practice. A small number of exceptional physicians, despite suspicion from the medical fraternity (Clarke, 2007; Creed et al., 2005; Read, 2005; Zalides, 2001; Skrine,

1987; Guthrie, Creed and Dawson, 1993), have undertaken further training in psychoanalytic or psychodynamic therapeutic approaches. They have been adapting these techniques to address persistent physical symptoms presenting within their patient populations. Such individuals have delivered their integrative approach and witness and record by informal case reports reduction in severity of such symptoms. These case reports also highlight the improvement in long-term non-disease-based physical conditions over relatively short periods of time by reaching more deeply beyond conscious 'psychosocial concerns'. Their clinical teams often include psychotherapists and clinical psychologists as an essential component of specialist treatment (Broom, 2000; Howlett and Reuber, 2009).

3.6.2. Enhancing healthcare practice

Mayor, Howlett, Grunewald and Reuber (2010) exemplify the work of psychotherapists employed in a particular UK medical out-patient clinic illustrating the value of the integration of psychotherapists within out-patient medicine as mentioned above. Comparing the outcomes of a brief augmented Short-Term Psychodynamic Psychotherapy intervention (STPP) for chronic non-epileptic seizure patients (a form of PPS) with an augmented Cognitive-Behavioural Therapy (CBT), an equivalent result emerges: Using STPP, 25% of patients became completely seizure free, in another 40% of patients 50% of these experienced reduction in seizures and a significant reduction in healthcare use. This prompts an examination of how these two main therapy modalities are defined, that is Cognitive Behavioural Therapy (CBT) and short-term psychodynamic psychotherapy (STPP) and the content of their 'augmentation' for PPS. These features are examined in the following chapter.

3.7. Study justification conclusion

In the past, under Diagnostic Statistical Manual of Mental Disorders, DSM-IV, (APA, 2000) the diagnosis and treatment of Medically Unexplained Symptoms (MUS) alternatively known as Persistent Physical Symptoms without organic cause (PPS), has caused confusion and uncertainty within healthcare (Creed et al., 2011). Within primary care, despite an estimated overall prevalence of 15-35% of all consultations being for MUS/PPS (Kirmeyer et al., 2004) there remains a lack of consistent and effective communication with patients shown in a qualitative study of patient experiences (Dwamena et al., 2009) and in primary research into the clinical consultation with those who suffer (Ring et al., 2005). There is little evidence of outcome satisfaction in primary care settings (Fink and Rosendal, 2008). The phenomenon, which is found in all healthcare settings, incurs substantial healthcare costs across the PPS population, which are estimated to be 10% of the annual National Health Service budget (Bermingham et al., 2010).

The revised Diagnostic Statistical Manual of Mental Disorders DSM-5 (APA, 2013) attempts to simplify the diagnosis of the most disabling forms of PPS to 'Somatic Symptom Disorder' (SSD), suggesting that this appears as a 5-7% incidence across the general population. Creed et al., (2011) evidence that those defined under the mental health category SSD require the skills of Liaison Psychiatry to support GPs in primary care; there are very few such services in England with the capacity to work with SSD. Furthermore, although researchers are looking for concurrent anxiety and depression (Sattel et al., 2012) which needs medical attention as a way of concurrently improving PPS, the majority of PPS sufferers in papers published between 2001-2014, are not necessarily found to have this co-morbidity (Steinbrecher et al., 2011).

It should be highlighted that the provision of effective services for those who continue to seek help to understand and to find relief from persistent signs of ill-health or physical dysfunction remains poor. This is despite the

availability of guidelines from the Royal College of Psychiatrists and Royal College of General Practitioners (RC Psych, 2009) and the Improving Access to Psychological Therapies guidelines for addressing PPS (IAPT, 2014). This updated IAPT positive practice guide suggests that Cognitive Behavioural Therapy (CBT) is the evidence-based treatment of choice for PPS that is associated with anxiety and depression. Thus, suggesting a Level 2, low-intensity guided self-help IAPT intervention for those with PPS not co-morbid with anxiety and depression. This recommendation is later challenged in the light of the cumulated findings of the realist evaluation.

The 'No Health Without Mental Health', UK Government paper (DH, 2011a) identifies evidence to assure that the integration of talking therapies into the care pathways for individuals with long term conditions and PPS will improve outcomes (2011a, para 3.15). The evidence also suggests that those situated in primary healthcare settings are ideally suited to identifying patients with PPS. The question of how interventions for PPS are implemented in the realities of practice remains under-researched.

In the context of this evaluation, the realist wide scoping of the literature justifies a detailed realist literature synthesis of evidence of efficacy and effectiveness of an alternative therapy modality for PPS intervention, Short-Term Psychodynamic Psychotherapy (STPP). Also, the current bio-psycho-social model of care and the way in which it is currently practiced in the real world has been identified as failing PPS sufferers.

The following chapter gives account of the focused realist literature synthesis of STPP for PPS, further supporting and providing underpinning and direction for this evaluation study.

Chapter 4: A Realist Synthesis of STPP Interventions

In Chapter 3, the broad and foundational realist scoping of the literature from 1990 to 2014 showed the complexity of diagnosing persistent physical symptoms in healthcare practice and the challenges to the delivery of effective interventions within non-acute healthcare settings. As an overview, Cognitive Behavioural Therapy is regularly found in systematic reviews of therapies for PPS as providing the greatest quantity of controlled trial evidence of efficacy for this patient group (Jackson, O'Malley and Kroenke, 2006; Kroenke, 2007) against usual care alone. This has been brought into IAPT guidance (2014) for PPS interventions in wellbeing services.

The informal evidence from clinical practice of applying psychodynamic principles for persistent sexual symptoms within Primary/Community Care suggested that a Realist Synthesis (Wong et al., 2013) of the literature may widen knowledge of what works in practice in the real world of healthcare delivery. Creed et al., (2011) in their extensively researched book on developing better clinical services for PPS, give a comprehensive account of 'high quality evidence' from controlled trials of CBT and short-term psychodynamic psychotherapy (STPP) for PPS. Their findings of a paucity of numbers of STPP trials in comparison to CBT for PPS, also offers a rationale for the realist examination of the efficacy and effectiveness of STPP interventions for individuals and groups of PPS sufferers.

This realist literature synthesis has the potential to broaden the realist concept of 'Programme Theory' (Pawson, 2013) for PPS interventions. The concept of programme theory (what works for whom and in what circumstances) is re-envisioned by Realist Synthesis authors Pearson et al., (2015) as the building of a 'conceptual platform'. As such, this will

indicate a core set of evidence-based processes and practical principles of what works for implementation in the real-world. In this instance, the hurdles to be overcome in order to effectively address PPS in healthcare have been identified in the previous chapter. The further in-depth literature synthesis shall at this early stage of developing PPS services particularly in non-acute settings, enhance the content of such a conceptual platform for effective interventions.

This chapter addresses Aim 2 of the evaluation (1.1), providing the critically examined evidence of efficacy and effectiveness of brief or short-term psychodynamic psychotherapy (STPP) modalities for PPS with a focus on primary care delivery. Also, the planned literature search and selection method are outlined. The found systematic literature reviews are scrutinised, followed by the detailed data extraction from systematically conducted primary studies of STPP interventions for PPS in non-acute healthcare settings.

The aim of the synthesis is to build on the literature reviews of Leichsenring (2005) and Abbass, Kisely and Kroenke, (2009). Both of these reviewing teams also assessed pre-post case series of STPP interventions for PPS. The STPP interventions shall be examined for 'augmentation' for addressing PPS in practice. These findings shall be compared to evidence-based adaptations for CBT interventions for PPS providing further direction for the methods for conducting this realist service evaluation.

The RAMESES standards for realist synthesis reporting (Wong et al., 2013) (see Appendix 13) built on the work of Pawson (2002) shall guide the layout of this chapter.

4.1. Realist-style Literature Synthesis

This focused phase of the literature synthesis shows by flow chart the selection of the literature (Fig.4.1). However, although this appears linear,

this was in effect an iterative cyclical process that was conducted over a four-year period. The concept of realist literature synthesis was introduced in the previous chapter and from this it was possible to show the challenges of addressing PPS encountered in health care settings. This challenges need to be identified before service design and effective delivery becomes feasible. Figure 4.1 represents a summary of a four-year endeavour to uncover efficacy and effectiveness studies using STPP approaches with PPS patients. During the research, for meeting the requirements for evidence-based practice in psychology (APA, 2006) the following the three arms were used: best research evidence available, reference to the patient's values and choices, and the relationship to clinical expertise.

4.1.2. Aims and objectives of the review

The aim of the continuing realist synthesis was to undertake a focused examination of the efficacy and effectiveness of short-term or brief psychodynamic psychotherapies (STPP) for persistent medically unexplained physical symptoms (PPS) in primary/community and non-inpatient care settings. This shall provide

a) a summary of outcome-findings of systematic literature reviews, from 2001 to 2014

b) an in-depth data extraction of all found systematically designed primary research published between 2001 and 2014 for evidence of STPP efficacy and effectiveness for PPS

c) a gauge of the acceptability of the STPP interventions and the expertise of the intervention providers

Following the wide scoping of the literature from 1990 to 2014 on the somatization phenomenon presenting in health care settings (Chapter 3), the objectives of the continued realist synthesis shall be to

a) design a search strategy that gives the greatest opportunity to discover the results of controlled and non-controlled systematically

designed and conducted primary STPP research studies for the treatment of PPS in primary/community (including out-patient) healthcare settings using published quality standards

b) to extract data in tabular and narrative form to answer the realist literature review questions

c) to use the findings to inform the developing focus of this thesis

4.2. Method

Sandelowski (2008) helpfully makes clear that a review labelled as ‘narrative’ or ‘qualitative’ does not necessarily equate with ’non-systematic’ or a review of poorer quality, but suggests that the objectivity of a review ultimately emerges out of a ‘disciplined subjectivity’. Although, it is established that a protocol can be clear and potentially auditable, it is also a surety that no repeat of the review will come up with exactly the same results. The views above act as a link from the traditional systematic literature review, to the systematic narrative review and on to the more recently developed RAMESES standards for conducting a realist synthesis (Wong et al., 2013, Appendix 13). Accordingly, with standards highlighted along with the prepared literature review questions for the primary research papers (4.4.2.), a planned search strategy and a protocol for the assessment of quality were formulated.

4.2.1. Parameters: inclusions and exclusions

Parameters: 2001-2014, all adult (18-64) and all languages.

Search Terms used to refine the search and inclusions:

- 'Somatoform Disorder*' (SDs)
- 'Medically Unexplained Symptoms' (MUS)
- Somatic Symptom Disorder (SSD)
- Somat*, somatisation and somatization
- 'psychosomatic disorders'
- 'persistent physical symptoms' (PPS)
- 'persistent sexual symptoms' (PSS)
- 'sexual dysfunction' AND 'somatoform disorder*'
- 'Primary care', 'primary healthcare', 'out-patient',
- Therapy, treatment, intervention
- 'Short-term psychodynamic psychotherapy' (STPP) and its variations (included Brief Psychodynamic Psychotherapy Dynamic Interpersonal Therapy (DIT); Psychodynamic Interpersonal Therapy (PIT), ISTDP, STDP, Mindfulness STPP, BOPT, Dance Movement Psychotherapy etc.)
- 'qualitative'; 'quantitative'

Exclusions in common with other studies, focused on participants with:

- Personality disorders
- Substance addiction
- Medication only interventions
- Eating Disorders
- Psychoses
- Dementia/Cognitive challenges
- Severe and disabling Myeloencephalitis (ME)

4.2.2. Literature sampling strategy

The following databases were searched using the parameters through an NHS Athens account, that was facilitated by the Senior Hospital Librarian.

- Cochrane Library Database of systematic reviews
- Database of Abstracts of Reviews of Effects (DARE)
- Health Technology Assessment database (HTA)
- NHS Economic Evaluation Database (NHS EED)
- Allied and Complementary Medicine Database (AMED)
- British Nursing Index (BNI)
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- EMBASE (Journal and conference coverage on bio-medical issues, wider than Medline)
- Health Management Information Consortium (HMIC)
- Medical Literature and Analysis and Retrieval System MEDLINE
- PsycINFO (database of abstracts of psychological research)

Further, a hand search of Systematic Reviews was made for references to PPS research that was not found in the databases above. A search alert of the Sexual and Relationship Therapy Journal over the years 2010-2014 was set up and scrutinised for research published conceptualising heterogenous persistent sexual symptoms as PPS. Search alerts were also set up for PsycINFO and NHS evidence websites using the search terms.

Additionally, the Pragmatic Case Studies Repository and Systematic Case Studies for Counselling and Psychotherapy were checked for links to the PPS phenomenon. Also

- Contacting experts and specialists in the field to provide further direction and access to unpublished material
- Networking through professional websites to obtain grey literature

- Obtaining conference abstracts and attending conferences where possible for further references
- Search of British Library Database of Theses

A flow diagram (Fig.4.1) depicts the numbers of papers found, number of papers which were excluded through screening and full text final selection. The search was undertaken, by an iterative process over time from August 2010 until December 2014.

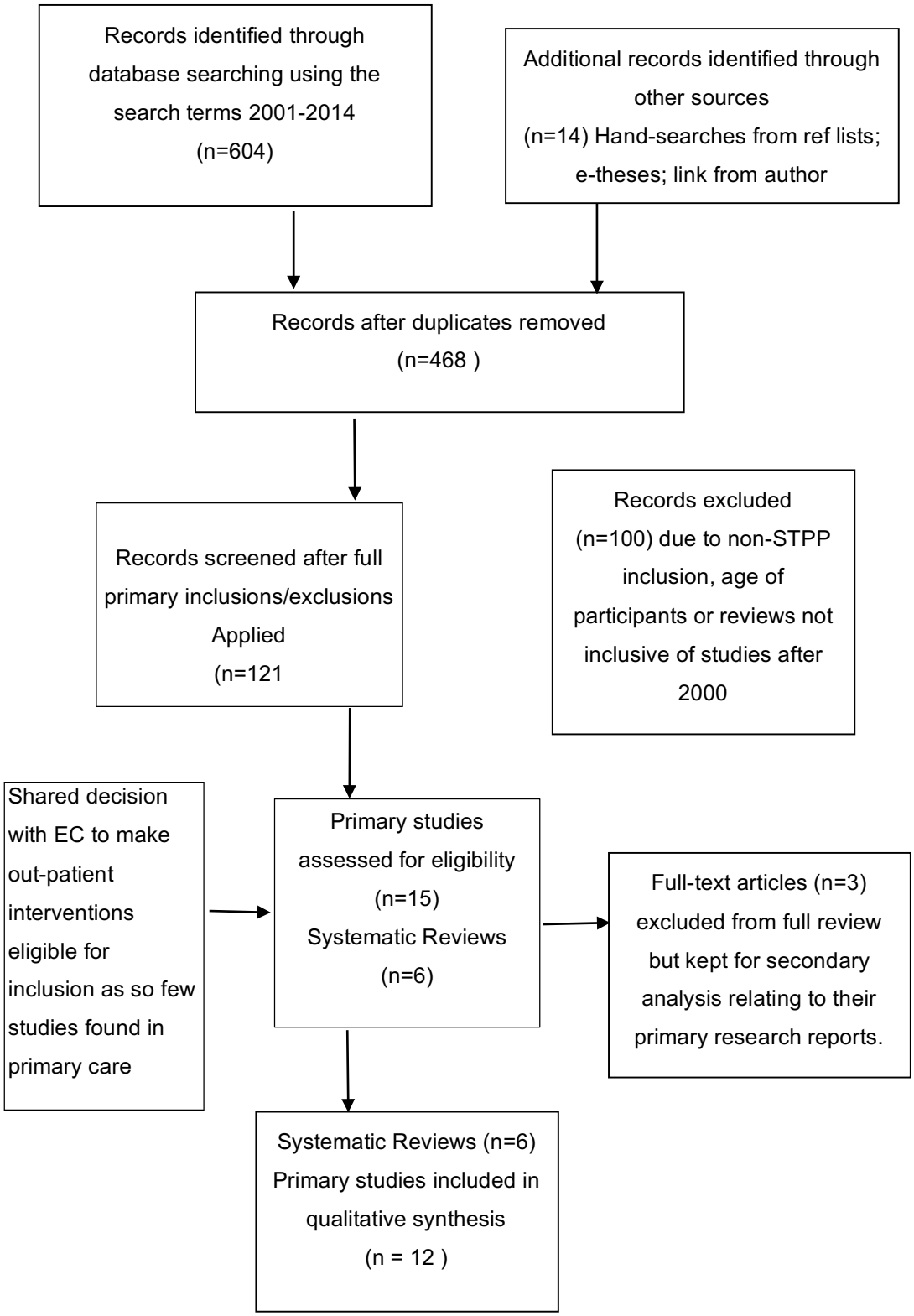

Fig. 4.1 Flow chart of realist literature iterative screening process

4.2.3. Literature Quality checks

The guideline of the Critical Skills Appraisal Programme (Public Health Resource Unit, CASP, 2006) was used to examine systematic literature review findings of short-term psychodynamic psychotherapy (STPP) interventions for persistent medically unexplained symptoms from 2001-2014. The following studies are examined by these guidelines, however, the majority of effectiveness studies were without a control group comparison. Moreover, the umbrella of Quality and Relevance Appraisal (EPPI Centre //eppi.ioe.ac.uk/cms), which is relevant to mixed method research found in some of the research designs of the primary studies, also helped to scrutinise the research papers. This effectiveness study includes such parameters, like, the examination of the trustworthiness of research design, appropriateness to the research question, appropriate focus and overall weight of evidence.

The review team comprised of the T-E, a healthcare researcher with experience in quantitative and qualitative research studies (E.C.) and, two Institute of Health Research academic supervisors (GR) and (LB). Checks and balances against bias in selection were thus facilitated during the three stages of the review: a) initial wide-scoping for literature from 1990 to 2014, b) selection of systematic reviews from 2001 to 2014, c) selection of primary research from 2001 to 2014.

4.3. Selection of systematic reviews and data extraction

The following six key reviews were selected for background:

Table 4.i) Six key reviews of STPP interventions for PPS 2001-2014(*Database of Abstracts of Reviews of Effects)

Authors and source	Title	Publication
Abbass, Hancock, Henderson, & Kisely (2006) PsyINFO & Cochrane Reviews	Short-term psychodynamic psychotherapies for common mental disorders	*Cochrane database for systematic reviews*, 2006 Oct 18 (4) CD004687
Abbass, Kisely & Kroenke (2009) *DARE & Evidence Based Reviews	Short-term psychodynamic therapies for Somatic Disorders	*Psychotherapy and Psychosomatics*, 78, pp.265-274.
Abbass, Kisely, Town, Leichsenring et al., (2014) (updating 2006 review)	Short-term psychodynamic psychotherapies for common mental disorders	*Cochrane database for systematic reviews*, 2014 July 1 (7) CD004687
Leichsenring (2005) DARE	Are psychodynamic and psychoanalytic therapies effective? A review of empirical data.	*International Journal of Psychoanalysis,* 86, pp. 841-868
Raine, Haines, Sensky, Hutchings, Larkin & Black (2002) DARE	Systematic Review of mental health interventions for patients with common somatic symptoms	*British Medical Journal (BMJ)*, 325, pp. 1082
Van Dessel, den Boeft, van der Wouden, Kleinstauber, Leone et al., (2014) Cochrane Reviews	Non-pharmacological interventions for somatoform disorders and medically unexplained physical symptoms (MUPS) in adults.	*Cochrane database for systematic reviews,* 2014 Nov 1(11) CD011142

Review findings extracted were:

- Search parameters
- Number of studies reviewed and if checked for quality
- Number of participants
- Results
- Review recommendations

The overall findings are discussed in narrative form below with the explanations given for exclusions shown in Appendix 11.

4.3.1. Narrative summary of findings from key literature reviews

The findings of controlled interventions for STPP with persistent somatic symptoms were checked for quality standards with the use of Critical Appraisal Skills Programme 10 questions. Then, the updated selection was checked by auditors EC and GR. This was followed by selection and scrutiny of the six systematic literature reviews for the first stage of the focused realist literature synthesis. A summary narrative of findings from the six systematic reviews is given below, each review is addressed with reference to Appendix 11 showing the full data extraction table.

Abbass et al., (2006) examined 23 randomized controlled trials (RCTs) (n=1431) of STPP of interventions for specific psychiatric disorders, including somatoform disorders. In their study, treatment interventions were found effective with modest to moderate benefit sustained in the long term. Moreover, Abbass et al., (2014) have since updated the 2006 review to February 2014, to finding 33 RCT studies comprising of 2173 patients receiving STPP (under 40 sessions) as an intervention for common mental disorders including somatic symptoms. Twenty of these studies could be used to build evidence for the outcomes selected. The outcomes showed in somatic (at the medium term), and in anxiety and depression symptom reduction (from the short-term), a significantly greater improvement versus the control groups in the short and medium

term. However, the authors caution that although STPP continues to show promise there remains a limited data availability due to heterogenous treatment delivery.

The Abbass, Kisely, Kroenke (2009) systematic review examined evidence for short-term psychodynamic psychotherapies (STPP) for Somatic Disorders. Their search was widened, as was the Leichsenring et al., (Part 2, 2004) report, to include controlled and un-controlled, before and after naturalistic studies for STPP interventions for PPS whether in individual or group therapy. The persistent physical symptoms of the studies included 'dermatological, neurological, cardio-vascular, respiratory, gastrointestinal, musculoskeletal, genitourinary, immunological, functional somatic symptoms, irritable bowel syndrome and chronic pain'. And, other PPS, such as, those conditions that are less linked to emotional dysregulation, including Crohn's disease, coronary artery disease, emphysema, bronchitis and Sjogren's syndrome (arthritis and dryness of the eye, etc.). In the reports, only 6 of the 23 studies described manualised treatment while all were conducted within the previous 25 years and represented 10 different countries of study.

The analysis of outcomes used 21 of the 23 studies and these reported significant (n=17) or possible (n=4) effects on physical symptoms (Abbass op.cit., 2009). Sixteen of the 21 studies reported the same on psychological symptoms of significant benefit (n=13) or possible benefit (n=3). Ten studies showed drop-out rates of the control group as significantly higher, Z being the number of standard deviations above the mean (95% CI [1.06, 2.25], Z = 2.25, p=0.02), than the STPP intervention group who were 54% more likely to stay in treatment. Outcomes were measured as short term (0-3 months) using the fixed effect model (ES = 0.58-0.78) relative to controls for reduction in general psychiatric symptoms, depression, anxiety and somatic symptoms. However, at medium term (4-9 months), outcomes using the fixed effect model (Cohen, 1998) with Cohen's *d* Standardised Mean Difference (SMD) showed

medium magnitude improvement for psychiatric symptoms (SMD= -0.56, 95% CI [-0.81, -0.31], $p<.0001$) and large improvement in somatic symptoms (SMD= -0.87, 95% CI [-1.37, -0.38], $p<.001$). For longer term (more than 9 months) post–treatment the difference, using the fixed effect model between the intervention and control groups, the reduction in somatic symptom severity was maintained. The authors suggest that their findings show STPP as promising for a range of persistent physical symptoms, reducing physical and psychological symptoms, increasing treatment compliance, social-occupational function and reduction in healthcare use.

Leichsenring et al., (2004) and Leichsenring (2005) asked the question whether psychodynamic and psychoanalytic therapies are effective. From this broad question, a narrative review was developed. Four of the 22 randomised controlled trial studies related to interventions for somtatoform disorder, but only one study (Creed et al., 2003) was published between the years 2001-2014. This study's sister paper (Creed et al., 2008) is analysed in the primary studies review at 4.6.2.

Overall the Leichsenring review showed STPP to be feasible and more effective than usual care in one study and significantly superior to the control groups in three studies. With reference to this, the review team found that effectiveness and quasi-experimental study designs did not systematically over-estimate the effects of psychotherapy interventions and that psychodynamic psychotherapy was shown to be cost-effective with outcomes stable at twelve month follow-up. The reviewer also recommended that the interpersonal process during the implementation of a therapy protocol should be studied to find out what works and how. Finally, Leichsenring argued for the inclusion of naturalistic studies alongside RCTs to explore alternative explanations of efficacy.

Raine et al., (2002) attempted to review mental health interventions for patients with common somatic symptoms to find out whether the results of

studies in secondary care equated with those conducted in primary healthcare settings. Twenty primary care studies and 41 secondary care studies, were found for Raine's broad review. The review found better results in the secondary care setting. The studies were reported to have too many differences in treatment regime and were methodologically weak with lack of demographic information, drop out details and quality controls. Also, the authors found a relative dearth of studies in primary care and recommended research identification of elements of interventions that could be used effectively in primary care. Pragmatic studies on unselected patients by doctors, nurses and counsellors in primary care were suggested to include information on the quality and content of the intervention and to use validated outcome measures.

Using systematic literature review, Van Dessel and colleagues (2014) examined further RCT and cluster randomized trials specifically for non-pharmacological interventions for somatoform and medically unexplained physical symptoms. Although 14 of the 21 studies were of forms of CBT, the mindfulness CBT (MCBT), psychodynamic therapies and integrative therapy were represented in the remaining seven studies. In the review, the results of all psychotherapeutic interventions were pooled showing a reduction in severity of symptoms against usual care or waiting list as controls. Of 10 of the studies, 1081 participants were analysed, with the results pre-post therapy suggesting small to medium effect (Appendix 11).

The authors found that the analysis of a CBT sub-group (excluding mindfulness CBT) against usual care showed similar outcomes as compared to the whole group analysis as above. However, when compared with 'enhanced care', it showed some common features in the use of relaxation techniques and breathing exercises, and CBT was not shown to be more effective. Due to heterogeneity and the lack of clarity of the content of the interventions, the authors conclude that the quality of the evidence of the review was low to moderate. Drop out was shown as 7 % higher in the intervention groups of 14 CBT studies compared to usual

care controls, N=1644, using Risk Ratio (RR acceptability 0.93, 95% CI [0.88, 0.99]). The authors recommend that the number of studies of other treatment modalities, other than CBT are undertaken.

4.3.2. Comparison of STPP with CBT for somatic disorders

The results above are reported to be similar to that of the CBT review for somatic disorders, (Kroenke and Swindle, 2000) which included 29 RCTs and 2 non-RCT interventions with diverse persistent physical conditions, using both 1:1 and group therapies. In this review, only 9 of the 31 studies have used therapy protocols. Kroenke and Swindle's review of CBT efficacy found definite or possible physical symptom benefits in 82%, and in psychological definite or possible benefit in 46%. Also, STPP interventions were found to deliver some benefit on at least one of the parameters for 91.3% of the participants, compared to 69% in RCT studies using anti-depressant medications alone.

The inclusion of controlled case series in naturalistic settings shows credible evidence that some patients with a wide variety of persistent physical symptoms in real-world settings can find improvement in psychological and physical functioning. The STPP modality intervention overall, offers good retention rates and reduced healthcare utilisation. Also, now the STPP modality intervention has the evidence to be used alone or as part of other treatment for individuals with persistent physical symptoms.

The authors Abbass, Kisely et al., (2009) indicate that the psychodynamic principle of developing awareness of unconscious processes through the facilitation of emotion, are further supported by the findings of their sub-analyses within the meta-analysis of their review. This, they report, shows strong effects for the more emotion-focused STPP models of intervention corroborating the findings of Diener et al., (2007). The latter, through a meta-analysis of the STPP literature, shows evidence that the facilitation

of an expression and understanding of emotion was found to be linked positively with patient outcomes in relation to PPS and as potentially having a core healing effect for individuals with somatic disorders.

4.3.3. Building a bridge from STPP to CBT through emotion

The Cognitive Behavioural authors of Affective CBT to address PPS, Woolfolk and Allen (2007) align with the observations of Abbass, Kisely et al., (2009) and Diener et al., (2007) suggesting that if cognitive-behavioural therapists are to attempt to address persistent (medically unexplained) physical symptoms in practice, then they urge the essential inclusion of 'affect'. This means the facilitation of the expression of emotion can be linked to the PPS and in making cognitive and personal sense of it within the therapy. The Affective Cognitive Behavioural Therapy (ACBT) model has been tested by RCT for somatisation disorder (Allen et al., 2006 a) (see 4.7.). The components of ACBT are relaxation training, behavioral management, cognitive restructuring, emotion identification, emotion regulation, and interpersonal skills training.

4.4. Selection of primary studies and data extraction

The recent Cochrane-Standard Systematic Literature Reviews concerning STPP for PPS, 2001-2014, are key to showing the efficacy of STPP as a therapeutic alternative to CBT (Abbass, Kisely et al., 2009). The second phase of the realist literature synthesis was to find all accessible systematically conducted primary research on STPP interventions for PPS from 2001-2014. This updates and broadens the Systematic Review of Abbass, Kisely et al., (2009) which included primary before and after research in naturalistic settings.

4.4.1. Twelve primary studies

Twelve heterogenous primary studies of STPP interventions for PPS were found during the cyclical search over time to December 2014 within the search parameters (Fig. 4.1). These studies are introduced (Table 4. ii) by author, source, title and publication.

Table 4.ii) Twelve primary studies of STPP interventions for PPS

Authors, date & source	Title	Reference
Abbass, Campbell, Magee and Tarzwell (2009) Link from Abbass, Kisely, Kroenke 2009	Intensive short-term dynamic psychotherapy (ISTDP) to reduce rates of emergency department return visits for patients with MUS.	http://www.istdp.ca/docs/CJEM_2009.pdf.
Carrington, Rock and Stern (2012) MEDLINE	Psychoanalytic thinking in primary care: The Tavistock Psychotherapy Consultation Model.	*Psychoanalytic Psychotherapy*, 26(2),102-120.
Creed, Tomenson, Guthrie et al. (2008) Linkedwith Creed et al., 2003PsycINFO	The cost-effectiveness of psychotherapy and paroxetine for severe IBS.	*Gastroenterology,* 124, 303-317
Guthrie, Margison, Mackay et al. (2004) PsycINFO	Effectiveness of Psychodynamic Interpersonal Therapy (PIT) training for Primary Care Counsellors.	*Psychotherapy Research*, 14(2), 161-175
Hinson, Weinstein, Bernard, Leurgans and Goetz (2006) Link from Abbass, Kisely (2009)	Single-blind clinical trial of psychotherapy for treatment of psychogenic movement disorders.	*Parkinsonism and Related Disorders,* 12, 177-180.
Junkert-Tress, Schnierder, Hartkamp et al.(2001) PsycINFO	Effects of short-term dynamic psychotherapy for neurotic, somatoform, and personality disorders.	*Psychotherapy Research,*11(2), 187-200
Mayor, Howlett, Grunwald and Reuber (2010) Link from contact with S.Howlett	Long-term outcome of brief augmented PIT for psychogenic non-epileptic seizures.	*Epilepsia* 51(7),1169-1176
Payne and Stott (2010) PsychINFO	Change in the moving BodyMind approach (on group work with MUS)	*Couns. & Psychoth. Res.*,10(4), 295-306.
Rohricht and Elanjithara (2013) MEDLINE	Management of Medically Unexplained Symptoms: outcomes of a specialist liaison clinic.	*Psychiatric Bulletin*, 38, 102-107.
Sattel, Lahmann, Gundel, Guthrie et al., (2012) Link from Tyrer et al., 2005	Brief psychodynamic interpersonal psychotherapy for patients with multisomatoform disorder,	*British Journal of Psychiatry,* 100, 60-67.
Tschuschke, Weber, Horn, Kiencke and Tress (2007) Link from Abbass et al**.,** 2009	Ambulante Psychodynamische Kurzgruppenpsychotherpie bie Patienten mit somatoformen Storungen	*Zeitschrift fur Psych., Psychol. und Psychotherapie*, 55(2), 87-95.
Ventegodt, Thegler et al., (2007) Link from Review by Abbass, Kisely, Kroenke, (2009)	Clinical holistic medicine in the treatment of experienced physical illness and chronic pain	*The Scientific World J.,* 7, 310-316.

4.4.2. Realist scrutiny of evidence

A realist scrutiny of the systematically conducted twelve primary research studies with the use of brief psychodynamic principles for adults with PPS seeks to answer the following questions:

1. What is the evidence of efficacy and effectiveness from studies near to naturalistic practice of STPP interventions for adult PPS from 2001-2014 in non-acute healthcare settings?
2. What is the evidence of the acceptability of the intervention?
3. What are the main features of the STPP therapy intervention as described by the authors?
4. What evidence is there of adaptation of the intervention to the needs and preferences of the individual?
5. How was the therapy experienced?
6. How were active ingredients explored?

In order to avoid creating an unwieldy and illegible grid, as recommended by Higgins and Green (2011) and Kitchenham (2004) the reported results of the primary studies were broken down into four separate tables (Table 4.iii) briefly summarised in narrative form and then synthesised for overall findings (Table 4.iv).

Table 4.iii) Realist data extraction tables created for the primary research studies

Table A	Table B	Table C	Table D
The study setting	The numbers involved	Validated measures utilised pre and post intervention	Detail of the therapy model and any augmentation
The STPP or types of intervention	The intervention and control group numbers (if present)	Results baseline, end of intervention	Exploration of how the therapy was experienced (indicating acceptability)
Frequency and length of intervention	Study drop-outs (indicating acceptability)	Results at 3-6 months or more (if present)	Exploration of active ingredients of therapy
Who delivered the therapy			

(see the populated tables A, B C & D at Appendix 12)

4.4.3. Data extraction from twelve primary studies

A narrative summary of data extraction from all Tables A to D is given followed by a realist summary of the primary studies and intervention results (Table 4. iv). For further detail please refer to Appendix 12.

Table A: Study design, patient setting, intervention, and delivery

Of the twelve selected primary research studies (2001-2014), one study was of RCT design (Creed et al., 2008) and a second, a controlled study (Sattel et al., 2012), the remainder was of pre-post designs. These 12 primary studies were set in various non-acute healthcare settings, which included out-patient clinics. The interventions were delivered by specialist and primary care providers, like, clinical psychologists, family physicians, primary care counsellors, psychotherapists, psychiatrists, social workers, dance movement therapists, all with a minimum of a two-year training in

psychotherapeutic interventions as extra to their professional discipline training. The exception was of a top-up three month training in Psychodynamic Interpersonal Therapy for accredited primary care counsellors (Guthrie et al., 2004) (see Appendix 12 for the full data set and Table 4.iv for a realist summary of each study).

All the short-term psychodynamic psychotherapies engaged with emotion with the use of either group-based or 1:1 intervention at a weekly, fortnightly, monthly or at other frequency. Sessions ranged in number from 1 to 8 (3 studies); and from 1 to 12 or up to 20 sessions (9 studies).

Table B: Number of participants in each study, numbers in control groups and drop-out (acceptability of intervention)

Intervention group sizes were found to vary from (n=10) to (n=50) for pre-post uncontrolled effectiveness designs and (n=107) to (n=257) for the controlled trials. Drop-outs indicated the patient choice and showed non-attendance for initial assessment from 16% -23% and drop out during the intervention 8%-58%. The highest drop-out, 58% was for an intervention in private healthcare practice (Ventegodt et al., 2007) and second highest, 40% from a study recruiting by referral from A&E admissions and seen for therapy in an out-patient setting (Abbass, Campbell et al., 2009). Where there were control groups (Creed et al., 2003) found 31% drop out for the STPP group and 50% drop out for the SSRI medication control group. Sattel et al., (2012) reported a 19% drop out for STPP and 27% drop out for the Enhanced Medical Care control group. This indicates a greater acceptability of the STPP intervention compared to the control groups.

Table C: Quality of life/mental well-being and physical symptoms scores, pre and post-therapy

Study measures were various, covering psychological distress and social functioning, global assessment of function. The physical and mental well-being results for the measures used are found in appendices (Table C, Appendix 12). Four of the twelve studies used the Patient Health

Questionnaire-15 for somatic symptoms. Each of the twelve primary studies outcome measures, including the PHQ-15 were assessed for suitability for the service evaluation and the selection justified in Methods (Chapter 5.3).

The outcomes of the five following studies, which did *not* show measure of longer term effects (Carrington et al., 2012; Guthrie et al., 2004; Hinson et al., 2006; Ventegodt et al., 2007; Abbass, Campbell et al., 2009), evidenced:

- medium to high significant effect in improved mental and physical symptoms at the end of therapy

Of the five following studies that measured longer term outcomes (Creed et al, 2003; Junkert-Tress et al., 2001; Mayor et al., 2010; Payne and Stott, 2010; Tschuschke et al., 2007), four showed:

- moderate to high significant effect in improved mental and physical symptoms with outcomes maintained at follow-up

Mayor et al., (2010) showed significance in reduced seizure frequency, but this was found not significantly correlated with improved mental or physical wellbeing scores (SF-36 Mental & Physical, CORE-OM and PHQ-15).

Two studies – one offering Body Oriented Group Psychotherapy (Rohricht et al., 2013) and the other, Sattel et al., (2012) which took referrals from out-patient clinics and private practice for 1:1 manualised 12 weekly sessions of Psychodynamic Interpersonal Therapy evidenced:

- high significance for reduced severity of somatic symptoms but non-significant results for depression

Rohricht et al., reported of those referred (N=106) to the specialist liaison clinic for medically unexplained symptoms, 29% (n=30) were found with depressive and or anxiety disorder, suggesting that even ‘sub-syndromal’ depressive symptoms, ‘mediated the effect of somatic symptoms’ (2013,

p.102). A ‘positive correlation’ was reported between the Hamilton Depression Scale (HRSD) and Somatic Symptom Scale (SOMS-7) total scores (r= -0.62, p<.01). No such correlation was found *within* the depressive disorder group, aligning with the study below.

The Sattel (2012) study reported:

- equivalence of outcome to CBT treatment effects for Bodily Distress Disorder (BDD) in comparison to a review of Behavioural Medicine (Looper and Kirmeyer, 2002)
- that the assumption that an improvement in depression leads to an improvement in somatic symptom severity is incorrect

The Tschuschke et al., (2007) study using psychodynamic brief group therapy delivered by psychoanalytically trained psychotherapists reported:

- moderate somatic and mental effects at the end of therapy
- which increased to high effect size at 6 months
- maintaining this gain at 12 months

This delayed added benefit has been shown in other studies of psychodynamic psychotherapies (Leichsenring, 2005).

Table D: Was the therapy model further outlined? How was the therapy experienced? Were the active ingredients of the therapy explored?

Abbass, Campbell et. al., (2009) used a patient satisfaction survey (a Likert Scale between 1-10 (one being the lowest score) to assess the satisfaction level among the therapy participants. Overall satisfaction with the intervention of those who attended after referral from Emergency Department (A & E) was rated at a mean of 7.4 out of 10 from satisfied to very satisfied. In answering what components were helpful, results

showed: gaining insights into the physical effects of emotion and an expressed benefit from the service.

Additionally, Payne and Stott's study (2010) using Dance Movement Psychotherapy in a community setting used a mixed method applied to a single case design and was able to use a grounded theory analysis to extract themes from the semi-structured interviews with patients and group facilitator pre and post-therapy intervention. From the analysed qualitative data, the findings showed more agreements than differences between the facilitator and the participants. The themes extracted were:

- the role of the facilitator is valued along with time and space to become aware of triggers to PPS
- linking feeling and circumstances to the triggers
- gaining awareness of the personal meaning of PPS
- learning how to avoid the triggers
- developing new personal strategies for day to day coping

Ventegodt's study of mindfulness STPP was complemented by 'body-work'. Of those who remained in therapy the authors identified by patient feedback, 'during the most intensive phase of the therapy, many patients felt "very bad" for a few days but none of the patients experienced severe or lasting side-effects.' (2007, p. 313).

A realist-style summary of the 12 primary studies is displayed at Table 4.iv) with p values for measures of change over time shown as p<.05*; p<0.1** and p.001***. For the detailed outcome results that were available from the studies please see Appendix 12, Table C.

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Abbass, Campbell, Magee and Tarzwell (2009) Intensive short-term dynamic psychotherapy (ISDTP) to reduce the rates of emergency department (ED) return visits for patients with MUS(PPS) *Pre-End of Therapy* *With review of ED visits at 12/12*	OP for PPS	• Referred through ED visit • Heterogenous PPS • (N=26)	• Intensive Short-Term Dynamic Psychotherapy (ISTDP) (Davanloo, 2005; Abbass, 2005)	• Psychologist • Snr Psychiatry Residents • Psychiatrist • Family Physician • 2 yrs use of the model	• 1 to 20+ weekly sessions	• BSI Global T1-T2 ** • BSI Somat T1 – T2 * • ED visits over the following year reduced by 69% • An ISTDP intervention on ED referrals who engaged in out-patient clinic (O-PC) impacted positively mentally and physically and in the reduction of emergency healthcare use

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Carrington, Rock and Stern (2012). Psychoanalytic thinking in primary care: The Tavistock Psychotherapy Consultation Model *Naturalistic* *Pre-End of Therapy*	PC	• Referred by GPs to a Community PPS service staffed by specialists • Heterogenous chronic PPS • Assessment only(n=77) • Assessment plus follow-up (N=44)	• Dynamic Interpersonal Therapy (DIT) (Lemma, Target, Fonagy 2011) • Mentalisation-Based Therapy (Bateman, Fonagy, 2004) • psychodynamic principles to support GP case-work	• Clinical psychologists • Nurses • Social Workers • Psychiatrists • Psychotherapists • Expertise in working with PPS & Mental Health	• 31% seen weekly • 40% seen fortnightly • 15% monthly • Flexible over 12 months	• 75-82% improvement for those referred from PC who entered therapy in primary care (PC) • Comparison to IAPT services of CORE outcomes in their first year at an overall medium effect ES (0.7) • Depression ES (0.9) & Anxiety ES (0.9) = large effect • Work & overall functioning was less improved than non-PPS at ES (0.6) =medium effect • This group of chronic PPS sufferers may benefit from more than one intervention episode

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Creed, Tomenson, Guthrie et al. (2008) The relationship between somatization and outcome in patients with severe Irritable Bowel Syndrome (IBS) *RCT-Control Group Treatment as usual (TAU)& Comparison with Paroxetine intervention group* *Pre-15/12 Post Therapy*	OP-Gastro-enterology	• Within 7 IBS clinics • Intractable (IBS) • (N=251)baseline for SCL-90 somat) • (n=65) for most severe somatisation score group	• Psychodynamic Interpersonal Therapy (PIT) (Guthrie, 1991) based on Hobson (1985)	• Therapists • Trained in PIT over 3/12 • Use of Therapy manual	• Up to 8 sessions over 3 months • 2-hour to assess • 45 minute follow ups	• At 6/12 ES (0.61) for psychotherapy intervention with greater improvement than TAU group who deteriorated • Physical improvement particularly for high scoring PPS, at no extra cost. Cost of intervention accounting for reduced healthcare use from pre to 12/12: for PIT, Paroxetine & TAU estimated at £683; £789 & £970 respectively. • PIT is shown as a cost effective intervention for high scoring PPS within a specialist clinic reducing physical debility

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Guthrie, Margison, Mackay et al. (2004) Effectiveness of PIT training for Primary Care Counsellors. *Pre-End of Therapy*	PC	• PC referral to PC Counsellors • Depression, and or somatization (or suicidal ideation) • (N=34)	• Psychodynamic Interpersonal Therapy (PIT) (Shapiro & Firth, 1987)	• PC Counsellors (BACP registered) • Newly trained in PIT techniques over 12 weeks	• 8 weekly sessions	• CORE-OM T1-T2*** • Clinically significant and reliable change was found in 50% of depressed or somatising patients treated by PIT during the counsellors' 3/12 training period

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Hinson, Weinstein, Bernard, Leurgans and Goetz, (2006) Single-blind clinical trial of psychotherapy for treatment of psychogenic movement disorders. *Pre-End of Therapy*	OP-Neurology	• Within-clinic referral • Psychogenic Movement Disorders (PMD) • (N=9)	• Brief Psychodynamic Psychotherapy (Davanloo, 1980). • Also prescribed anti-depressants or anxiolytics to treat co-existing anxiety or depression	• Senior Psychiatrist • Experienced in brief Psychodynamic Psychotherapy	• 12 sessions weekly	• Measures of physical disorder and dysfunction showed PMDRS T1-T2 * • Changes in depression HRSD T1-T2 ** • Anxiety Beck Anxiety T1-T2 ** • Global Assessment of Function GAF T1-T2 ** • Results suggest that the STPP intervention for unremitting PMD is effective in improving both mental and physical function

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Junkert-Tress, Schnierder, Hartkamp et al. (2001) Effects of short-term dynamic psychotherapy for neurotic, somatoform, and personality disorders. *Pre-End of Therapy and at 15/12 post therapy*	OP PPS	• Within clinic • Heterogenous PPS • (N=24)	• Short-term Dynamic Psychotherapy Therapy (STDP) (Strupp & Binder, 1984)	• Psychotherapists • Min 2 year experience in STDP	• Up to 25 weekly sessions	• The Global Severity Index SCL-90-R somat showed ES (0.69) by the end of therapy and at 6/12 ES (0.60) • The study indicates that moderate improvement in physical and psychological adjustment is maintained at six months post-therapy using the STDP intervention within a specialist non-acute setting

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Mayor, Howlett, Grunwald and Reuber (2010) Long-term outcome of brief augmented PIT for psychogenic non-epileptic seizures. Service Review, Retrospective Analysis: Pre-Long-term follow-up 1-5 years post-therapy	OP Neurology	• OP clinics in 2 hospitals • Non-Epileptic Seizure (NES) • Baseline all groups (N=47)	• Brief Augmented Psychodynamic Interpersonal Therapy (PIT), adapted (Hobson, 1985)	• Senior Psychotherapist • Experienced within the speciality	• Weekly or fortnightly up to 19 sessions • 2 hour assess	• Between 12-61 months median seizure frequency improved from 6-1 per month** • 22.5%, n=12 had become seizure-free • 40.4%, n=19 had a reduction in $> 50\%$ of seizures • Healthcare utilization reduced from baseline to follow up* • Brief Augmented PIT is shown as effective in a specialist non-acute setting and maintained in the longer term • No correlation found between PHQ-15, CORE-OM & SF-36 and lower seizure rate

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Payne and Stott (2010) Change in the moving BodyMind approach: Quantitative results from a pilot study on the use of the BMA to psychotherapeutic group work with patients with MUS. *Pre-3/12 Post Therapy*	PC	• Self-referral from PC to pilot group • Heterogenous PPS • (N=17)	• Adapted Dance Movement Therapy (DMT) to Dance Movement Psychotherapy (DMP) • With Bodywork (Adler, 2002, Pallero, 2006)	• Adapted Dance Movement Therapist • Min 2 years	• 12 weekly • 2-hour group sessions	• CORE-OM on baseline wellbeing to 3/12 follow-up*** with ES (0.72) in line with medium to high effect (compared to other studies) • DMT using psychodynamic principles plus body-awareness for those who self-referred to a pilot group in a PC setting is shown to be effective for physical and mental wellbeing at 3/12 follow-up

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Rohricht and Elanjithara, (2013) Management of Medically Unexplained Symptoms: outcomes of a specialist liaison clinic. Pre-3/12 Post-Therapy	Community Mental Health (MH) for PPS	• Referrals from GPs, MH & Medical OP (N=106) • Heterogenous PPS • Intervention group (n=12)	• Body-orientated psychological (BOPT) group therapy (Rohricht & Elanjithara, 2013)	• Psychiatrists • Trained and experienced in BOPT group therapy	• Over 24 months group intervention Up to 15 sessions	• Somatic symptoms scores using PHQ-15 baseline 17.7(3.3) to 3/12 follow-up 15.1(4.9)* reduction in severity • Depression scores shown as non-significant using HRSD baseline 19(7.7) to 3/12 follow-up 18.2(7.9) • Group BOPT is found to maintain improvements in PPS at 3/12 with reduced specialist referrals ** and ED attendance * but had non-significant impact on depression indicating that a 1:1 intervention may need to be offered as follow on from the group intervention

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
Sattel, Lahmann, Gundel, Guthrie et al (2012). Brief psychodynamic interpersonal psychotherapy for patients with multisomatoform disorder. *Controlled with Enhanced Medical Care (EMC) control group: Pre-End of Therapy and 9/12 Post-Therapy*	OPPsycho-somatic University Depts.	• Referred from OP Neurology, Internal Medicine, Pain & Orthopaedic PPS found within the referring clinics • HeterogenousPPS • (N=107)	• Psychodynamic Interpersonal Therapy (PIT) (Guthrie, in Hardy, Barkham, Shapiro et al., 2011).	• Psychologists • Physicians • Min 3 years training in psychotherapy and training in use of therapy manual	• 12 weekly sessions • 1st session 90 mins, follow-up sessions 45 mins	• PHQ-15 baseline 15.2(5.2), at end of therapy 13.8(5.3) and at 9/12 follow-up 12.7(5.8) • 43% reported 5 or more points in reduced somatic severity • 44% were found with major depression with no significant difference between groups post therapy • Between group effect ES (*d*=0.42) for physical symptoms is suggested as of moderate benefit to patients, superior to EMC, consistent with CBT interventions for PPS but maintained with significance at 9/12

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
						• PIT in a specialist non-acute healthcare setting is shown to improve PPS but not depression
Tschuschke, Weber, Horn, Kiencke and Tress (2007). Ambulante Psychodynamische Kruzgruppenpsychotherpie bie Patienten mit somatoformen Storungen. *Pre-End of Therapy and 12/12 Post Therapy*	OP	• Out-patient group therapy • Heterogenous PPS • (N=49)	• Intra-psychic dynamic group therapy (Tschuschke, Horn, Ott & Tress, 1998)	• Psychotherapists • Psychoanalytically trained	• 20 weekly x 90 minute group sessions.	• SCL-90 T1-T2 *** • At end of therapy ES (.48) • At 6/12 effect on physical and mental status ES (.61) • At 12/12 ES (.76) • GAF T1-T2 *** • at 6/12 ES (1.24) • at 12/12 ES (1.36) • High effect sizes on PPS are found at 12/12 post therapy following STPP group therapy in a specialized non-acute healthcare setting

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
						• Poorer outcomes were noted for those with comorbid personality dis.
Ventegodt, Thegler et al. (2007) Clinical holistic medicine (Mindful, short-term psychodynamic psychotherapy complemented with body-work) in the treatment of experienced physical illness and chronic pain. *Pre-End of Therapy*	Private health clinic	• Self-referrals to private clinic • Heterogenous PPS with self-rating of 'seriously ill' • (N=31)	• Mindfulness Short-term Psychodynamic (MSTPP) Psychotherapy (STPP) with undefined 'Bodywork' (Ventegodt, Anderson, Merrick, 2003)	• Holistic Medicine Masters Students • Psychotherapists • Psychodynamic & bodywork training within School of Holistic Medicine	• 20 sessions over 14 months	• QOL Physical*** • QOL Mental** • QOL1*** • At baseline all self-rated as physically bad or very bad • At end of therapy 12/31(38.71%) self-assessed as physically well with 33.3% good or very good and 66.7% improving (neither bad nor good) • MSTPP shows efficacy for PPS within a private healthcare setting but the process can feel traumatic to some patients. More clarity is

Table 4.iv) Overview summary of primary study results						
Primary research study	Healthcare context Out-patient (OP)Primary Community care (PC)	Referral route Presenting PPS & (N=)	Type of STPP intervention	Delivery by type of healthcare professional & length of experience	No. and frequency of sessions &length of session if exceptional+	Measures & Results Effect sizes (ES), or Mean(SD) change over time *-*** = significance (see end of table) Baseline End of therapy Longer term with author summary
						needed regarding the content of the therapy

p<.05*, p<.01 **, p<.001***

Apart from the Payne and Stott study no other studies reported qualitatively how the patients perceived the therapy itself and none explored the active ingredients of therapy intervention used. However, Hinson et al., (2006) recommend that the study of the specificity of the therapeutic intervention would be helpful. All the studies used some form of short-term psychodynamic therapy or the basic principles of brief psychodynamic therapy, either directly or indirectly.

As with Cognitive-Behavioural Therapies it is important to appreciate the variants that are used within named therapy modalities. This has been noted as a recommendation of Sumathipala's meta-analysis of efficacy of treatment for patients with PPS concerning CBT interventions (2007). The following short-term psychodynamic therapies were identified and referenced within the primary research papers and were examined for detail of content and any added techniques employed.

4.5. Examining the evidence-based STPP approaches to somatisation

The different variations of the Short-Term Psychodynamic interventions for PPS of the twelve selected primary studies were extracted and examined to find any common factors.

4.5.1. Dynamic Interpersonal Therapy (DIT)

Carrington et al. (2012) with the use of DIT, keep in mind the complexity in predisposing, precipitating and perpetuating factors. Other factors like, affect recognition, differentiation, and amplification and interpretation, addressing transference in the therapy dyad are joined by directive techniques to try new ways of relating. Luyten et al., (2012b) offer a comprehensive account of DIT.

4.5.2. Brief interpersonal therapy, also known as Psychodynamic Interpersonal Therapy (PIT)

The Creed et al., (2008), Guthrie et al., (2004), Sattel et al., (2012) studies used PIT. PIT is shown to be effective by Guthrie et al., (1991) and is based on Hobson's Conversational Model (1985). PIT is found to be manualised by Shapiro and Firth, (1987). Creed's study (2003, 2008) delivered eight sessions of STPP for severe Irritable Bowel Syndrome (IBS) (using the Shapiro and Firth model) and found equivalent outcomes of efficacy compared to the anti-depressant Paroxetine control group. Similar to the 'mentalisation-based therapy', that was used by Sattel et al., (2012) (see Luyten et al., 2012b) for further explanation), PIT develops empathy and awareness in relation to self and others and reflectively establishes links to bodily-state and emotion (Bateman and Fonagy, 2004). This therapy encourages discussions of emotional symptoms in depth and also explores in detail the emotional factors. This therapy helps in generating links between emotion and PPS by identifying them. Bodily relaxation therapy is also included in the PIT.

4.5.3. Brief Augmented Psychodynamic Interpersonal Therapy (Augmented PIT)

Augmented PIT is used by the Mayor et al., (2010) study. It is again based on Hobson, (1985) with some augmentation, like, symptom/emotion diary; tracking somatic symptoms and linking them with emotional triggers; identifying and changing unhelpful patterns in relationships; symptom control by breathing exercise; sensory focusing; relaxation; techniques to control autonomic arousal; goal-setting; enlisting family support; exposure - linking memory with emotion without re-traumatising; effective processing of emotion; noting pre-disposing, precipitating and perpetuating factors (Howlett et al., 2007).

4.5.4. Short-term Dynamic Psychotherapy (STDP)

The primary study by Junkert-Tress et al., (2001) is based on Strupp and Binder's Time-limited Dynamic Psychotherapy (1984). STDP is augmented by the use of the Model of Cyclic Maladaptive Pattern (CMP) with an emphasis on analysis of transference in the therapist-patient relationship and key conflictual relationships. In this therapy, breathing and relaxation techniques can be included.

4.5.5. Mindfulness Short-term Psychodynamic Psychotherapy

The Ventegodt et al., (2007) study refers to Ventegodt et al., (2003) for an explanation of Mindfulness Short-Term Psychodynamic Psychotherapy (MSTPP) with 'Bodywork'. MSTPP is described as a fast and efficient holistic tool for the generic therapy relating to physical, mental, existential and sexual problems (Ventegodt et al., 2003).

4.5.6. Brief Psychodynamic Psychotherapy/Short-term Psychodynamic Psychotherapy (BPP or STPP)

The Hinson et al., (2006) primary study used an STPP model based on Davanloo's (1980) Intensive Short-term Dynamic Psychotherapy (ISTDP), underpinned by the 'Brief Psychotherapy' of Malan (1963) and Michael and Enid Balint (1957). For evidence of efficacy, with the use of this therapy, one can refer to the meta-analysis of Abbass et al., (2012). In this therapy, the focus is on early life experiences, parenting dynamics, personality traits and linking these to current emotions and behaviours. Also, prescriptions of concurrent anti-depressants or anxiolytics are made as a part of medicated treatment during this therapy as indicated. Breathing and relaxation techniques are used as required in the moment of therapy.

4.5.7. Intensive Short-Term Dynamic Psychotherapy (ISTDP)

Abbass, Campbell et al., (2009) have based their study on Davanloo's technique using ISTDP (1990) in part expressed at para 4.5.6. and Abbass' (2005), emotion-focused interviewing. The focus is on examining past strong emotional activation and its physical effects; working together, examining unconscious anxiety affecting striated or smooth muscle, motor tone or cognitive functioning. Techniques to build anxiety tolerance, deep breathing, progressive muscle relaxation are also used in the therapy as required.

4.5.8. Adapted Dance Movement Therapy (DMT)

The Payne and Stott (2010) study used aspects of psychodynamic principles based on Adler, (2002) and Pallero, (2003). Body language and gesture are combined with words. This emphasises the connection between physicality, feelings, thoughts, beliefs, symbolic non-verbal, verbal and imagination.

4.5.9. Body-orientated psychological therapy (BOPT)

The Rohricht and Elanjithara (2013) study, used BOPT based on Lahman et al., (2009). This combines the verbal and non-verbal with focus on emotional processing and body/self-perception. It is suggested, that better outcome is achieved by not directly addressing psychological processes, but using a subtle integration of psychological and physical aspects as done in this therapy. Moreover, functional relaxation and guided imagery is included in this study.

4.5.10. Common STPP augmentation for PPS

In summary, there are subtle variations of STPP for PPS intervention. Common themes found appear to be:

- observing and working with the impact of emotions on the body
- facilitation of experiential change during the intervention
- exploring the circumstances from which the persistent physical symptoms began or are exacerbated
- examining patterns of personal response to the PPS
- relaxation and breathing exercises

The realist literature findings and the detailed data extraction process has shown the effectiveness of augmented STPP interventions for adult heterogenous PPS sufferers. These were otherwise hidden from Cochrane Standard Systematic Literature Reviews. From the reviews of STPP, Abbass et al., (2014) showed that STPP facilitates significantly greater improvement in PPS, anxiety and depression components. This is especially when compared to control groups in the medium and longer term with modest to large gains across the heterogenous populations. Mayor et al., (2010), Howlett and Ruber (2009) show results of augmented STPP at least equivalent to CBT-based intervention for a similar patient group. This invites again, an examination of CBT adaptations for engaging with PPS during therapy.

4.6. Affective CBT theoretical/practice perspectives

The scrutiny of the therapy interventions of the 12 primary STPP studies above shows common augmentation when addressing PPS with the individual. Here, the augmentations of Affective Cognitive Behavioural Therapy for PPS of Woolfolk and Allen (2007) are explored to discover how the STPP interventions above compare to recommendations for CBT interventions for PPS.

Cognitive Behavioural researchers Allen and Woolfolk, suggest that in the past CBT has been used to control and eliminate negative emotions by restructuring of thinking patterns (2006b). In their recommendation of Affective CBT (ACBT) for PPS it is argued, from the work of experiential therapists, that both eliciting and facilitating the processing of emotions enhances CBT for this patient group and enables 'great benefits' for patients (Woolfolk and Allen, 2007, p.150). Some of the so-called 'third-wave' cognitive-behavioural therapies have returned the focus of CBT towards valuing and accepting emotion as in Acceptance and Commitment Therapy (Hayes et al., 1999). There is a further emphasis on embracing life events and emotion without judgement as in Mindfulness-based CBT (MBCT), which was developed by Segal et al., (2002) for reduction in frequency of relapse in depression.

Affective CBT has now been empirically tested and it shows that fifteen months after baseline, somatization symptoms were significantly less severe in the group treated with ACBT. Patients treated with ACBT also were more likely to be rated as either very much improved or much improved (40%, n=17) than patients treated only by Enhanced Medical Care (Allen et al., 2006a). Allen and Woolfolk (2013) urge further enquiry that as multi-faceted interventions, the how and why aspects of CBT and ACBT work is unknown. These authors suggest, 'CBT and ACBT are likely to be the treatments of choice by default as no other intervention has demonstrated similar efficacy' (p. 180).

However, the detailed findings of the six systematic literature reviews above show the efficacy of STPP interventions for persistent heterogenous somatic symptoms. The realist literature synthesis of the 12 primary studies, from 2001-2014 showing enhancements in STPP therapies for PPS, also show effectiveness in non-acute healthcare settings. The following shows the components of Woolfolk and Allen's ACBT for comparison to the STPP interventions.

4.6.1. Phases of ACBT intervention (Woolfolk and Allen, 2007)

Phase 1

- relaxation training reducing physiological arousal using progressive muscle relaxation and diaphragmatic breathing
- non-judgemental exploration of somatic symptoms
- behavioural management, activity pacing, sleep management

Phase 2

- identifying unique patterns of cognition and expression of emotion to create a formulation
- Cognitive restructuring
- Recognition and differentiation of emotion
- Emotional regulation
- Interpersonal skills training

Phase 3

- Enhancing interpersonal functioning
- Confronting the sick role

With this, familiar components now come into view showing a degree of simple commonality across ACBT and augmented STPP for addressing PPS. Overall, both appear to combine the behavioural activities such as body relaxation and breathing exercises and the non-judgemental exploration and appreciation of emotional components of PPS in response to patient need.

4.7. The case for examining mechanisms of change

The planned realist literature synthesis of meta-analyses of controlled trials and updated primary studies of controlled and non-controlled STPP interventions for PPS (2001-2014) showed both efficacy and effectiveness

of STPP for PPS. The effectiveness of the real-world STPP interventions that were not included in Systematic Literature Reviews of evidence-based efficacy confirmed the RCT findings (Abbass et al., 2006; Abbass et al., 2014; Raine et al., 2002; Van Dessel et al., 2014) of effective STPP interventions with adaptations for PPS. These findings are now made known by this realist approach to the literature. The results across the heterogenous studies showed minimal variations in significance for the reduction in severity of persistent somatic symptoms. These results showed greater consistency in medium to high significance for PPS and mental health improvement than those of the RCT studies of non third generation CBT for PPS reviewed by Van Dessel et al., (2014).

All the STPP interventions hold in common the expression of emotion and the facilitation of developing understanding of the link between emotion and persistent symptoms and the 'in the moment' use of relaxation techniques to reduce high stress responses. The realist literature synthesis shows that these aspects of the STPP interventions provide not only a 'third generation' brief psychodynamic foundation as described by Levenson (2010) but a link to the 'third generation' cognitive behavioural therapies that engage specifically with emotions for interventions concerning PPS (Woolfolk and Allen, 2007).

Kazdin's argument (2008) for studying process and mechanisms of change in context, which are found in Chapters 2 and 5, suggested by Leichsenring, (2005) are combined with the call foran emphasis on pragmatic studies in Primary Care (Raine et al., 2002). Furthermore, Luyten, Blatt and Mayes (2012a) from the psychodynamic perspective of their empirically supported Mentalisation-Based Therapy (MBT) and Allen and Woolfolk (2013) from the ACBT perspective show common concern, that how and why the process of therapy works is systematically examined.

Moreover, cross-therapy modality support has been found, urging the study of the patient/therapist dyad in context. In the world of evidence-

based medicine and therapy, there is a current consciousness of the challenge to translate research findings into practice and also to take care of the clinical insights that may be lost as we attempt to quantify and objectify (Luyten et al., 2012a). These concerns and recommendations provide further justification of this research-evaluation process and shall be facilitated by focusing on the detail of the live engagement with PPS through a realist service evaluation lens.

4.8. Summary

The findings of the realist synthesis with the use of Level I and Level II evidence from Cochrane Standard Systematic Literature Reviews were complemented by the results of systematically conducted, largely uncontrolled effectiveness studies set within naturalistic practice, 2001-2014. Additionally, six further studies have broadened the Abbass et al., (2009) wider literature review, consequently showing that uncontrolled before and after studies bring systematically derived evidence of the effectiveness of STPP interventions for the diverse forms of real-world PPS. Abbass also notes that although systematic reviews by Jackson et.al., (2006) and Kroenke (2007) find CBT and anti-depressants to offer the most evidence-based treatments for somatic symptom disorders, the systematically-derived STPP intervention findings for PPS (Abbass, Kisely et al., 2009) show another effective, therapeutic alternative.

Of the twelve STPP primary research studies selected, five studies showed medium to high effect in improvement of mental and physical symptoms from baseline to end of therapy. Five further studies measuring longer-term outcomes show persisting medium to high significant effects in mental and physical symptoms. Two studies, one including Body Oriented Group Psychotherapy (Sattel, 2012; Rohricht et al., 2013), showed as exceptions high significance for reduced severity of somatic symptoms but borderline non-significant results for depression. Sattel reported that the assumption that an improvement in depression leads to improved somatic

symptoms is therefore incorrect. Mayor et al., (2010) find none of the validated measures used show any relationship to the significant reduction in seizure frequency.

Moreover, evidence was found of lower drop-out for the STPP interventions compared to treatment as usual (TAU), enhanced medical care (EMC) and CBT interventions indicating a broad acceptability to patients of a brief psychodynamic approach to their symptoms. Payne and Stott's study (2010) showed extracted themes of what aspects of the intervention were valued by the participants, like, becoming aware of triggers by linking feeling with circumstances, gaining awareness of the personal meaning of PPS, learning personal strategies for day to day coping.

The evidence synthesised here shows the effectiveness of Short-Term Psychodynamic therapies in real-world non-acute healthcare settings as a valuable alternative intervention for PPS. This material evidence was largely hidden from the scope of the majority of systematic literature reviews. Also, the inclusion of pragmatic, naturalistic, before and after uncontrolled psychotherapy studies, is found as Leichsenring noted, not to deliver an over-estimation of effects (Leichsenring, 2005). This supports the argument for redefining the scope of 'best research evidence' identified as a pressing need by Rawlins (2008) and Barkham et al., (2012) and by Pawson (2013). This realist synthesis of the literature, meeting Aim 2 of the evaluation, has widened an awareness of common factors identified across the main therapy modalities for PPS, not found previously published.

Thus evidence builds towards a broader programme theory, or conceptual platform of principles (Pearson et al., 2015) for service enhancement to effectively engage all kinds of PPS sufferers. Researcher recommendations across therapy modalities are unanimous in calling for the study of therapy process with PPS. The study of person-to-person engagement within the T-E therapy process shall therefore, develop

further knowledge of context-mechanism-outcome of principles for engagement with PPS. Thus, with references to the theoretical underpinning provided by the realist synthesis, these principles and processed shall be recognisable across psychotherapeutic therapy modalities. The following chapter critically discusses the development of the realist service evaluation methods with particular attention to its ethical design.

Chapter 5: Methods Part I and Part II

5.1. Introduction

Service evaluation is a process that embraces all forms of available data from day to day practice, for accountability and learning more about context and delivery to improve practice (Chelimsky, 1997). Seasoned CBT researchers Deary et al., (2007) recognise the need for prospective, more qualitative, less modality biased examination of the nature of PPS and how it is experienced by the individual. They identify the need for greater knowledge about what mediates and moderates the 'medically unexplained symptom' (PPS). However, accessing, analysing and publishing extracts of therapy process data on sensitive personal subjects is a particular ethical challenge.

5.1.1. Aims of Part I and Part II

This Methods Chapter meets the evaluation Aim 3 (1.1.). Part I and II identifies the evaluation questions that are answered from within context quantitative measures and through the reflexive qualitative data analysis of four full cases of therapy. Individual confidentiality is a primary legal obligation for health and mental wellbeing interventions irrespective of whether an explicit contract has been signed (DH, 2003; DH, 2010). It is poignantly relevant and applicable to the reputation and trustworthiness of counselling and psychotherapy interventions in which sensitive subjects arise (Bond & Mitchels, 2014). Furthermore, the reduction of risk of harm to counselling and psychotherapy research/evaluation participants and the ethical development of the findings shall be underpinned by the BACP Ethical Framework (BACP, 2015) (5.2.) and addressed by the evaluation methods selected (5.3).

The objectives of Part 1 of the Methods Section include enacting ethical principles to reduce risk of harm to participants when developing

- the evaluation questions (5.3.1.)
- case selection (5.3.2.)
- gaining ethical approval (5.4.)
- a fully informed as possible consent process (5.5.)
- continued consent and the reduction in disturbance to usual therapy (5.5.)
- data protection and storage (5.5.1.)
- dissemination and publication of findings (5.5.2.)
- the critical selection of tools and data gathering (5.6.)
- quantitative analytic plan (5.7.)

The objectives of Part II in meeting Aim 3, include the critical development of:

- methods to answer therapy process questions (5.8.)
- structured reflexivity for the T-E (5.9)
- the preliminary analytic framework (5.10-5.11)
- the overall qualitative analytic protocol (5.10-5.11)
- expected clinical outcomes (5.12)

Through this chapter the reader shall be able to orientate himself with the ethical generation of the quantitative and qualitative data, to the planned analyses and to the collation of findings. Also, Part I and Part II analytic findings are found in Chapters 6-8 answering the evaluation questions.

5.1.2. Consultation with stakeholders

Realist Evaluation projects are often organisation or government-led to provide local evidence of how interventions work for whom in order to enhance policy underpinning interventions for real-world situations (Pawson, 2013). More often a researcher is invited into the organisation

to conduct the evaluation. A Realist Evaluation ensures the study of the particular context of the intervention, the resources required to engage with a mechanism of change that works in situ. A developed understanding of the situational human response to those resources is created. As an internal self-generated but employer supported realist evaluator, consultation and engagement with stakeholders, essential to Realist Evaluation (Wong et al., 2013b), took a unique route.

5.1.3. Consultation with stakeholders for this study

With reference to the nature of the consultations, a total of eight broad events are laid out below that relate to the requirements of a realist evaluation (Pawson, 2013). These are summarised in Table 5.i).

Table 5.i) Consultation with stakeholders

Stakeholder	Consultation
Patients engaging with the Psychosexual Counselling Service	Scrutiny of responses to the routine feedback questionnaire
UK Government	Government directives, papers, advice
Employer: Line Manager, Research Lead, Medical Director	Presentations, gaining feedback, validation by successful doctoral funding application, gaining advice re dissemination
Research and Clinical Audit Group	Presentation, feedback in the form of successful grant application of £5,000
Clinical Team	Regular discussion through the research process, seeking comment, observation, opinion
New Chief Executive	Invitation to presentations, email discussion
Cambridgeshire PPI	Consultation on participant paperwork-sending papers and receiving feedback
Professional Organisations	Telephone, email, conference attendance, face to face discussion on measuring outcomes and interventions for PPS. Continued case consultations with external clinical supervisor.

The first consultation was conducted through the patient feedbacks that were completed in confidence at the end of therapy undertaken by the Psychosexual Counselling Service over previous years. Primarily, it showed that the majority of those completing the questionnaire were satisfied with the intervention and that there was a self-rated substantial increase in confidence in managing their presenting persistent sexual symptoms not due to or wholly explained by medical condition. It also

reflected a decrease in the presenting symptom severity and confidence in the service administration and delivery.

The process of consultation was instrumental to shaping the research design further to ensure the outcomes could be used to enhance the service and practice development with PPS. The National Institute of Health Research (NIHR), by Promoting Public Involvement (PPI) in the research and evaluation process support the identification of ethical issues and how they might be addressed from a participant perspective.

Consultation regarding case-work using the College of Sexual and Relationship Therapists (COSRT) and the British Association for Counselling and Psychotherapy (BACP) standards for supervision practice, continued seamlessly, as usual, with clinical supervisor (RW). Consultation on the analytic process was maintained with academic supervisors (GR and SB and later, EC).

5.2. The BACP Ethical Framework: foundational principles

The updated British Association for Counselling and Psychotherapy (BACP, 2015) Ethical Framework provides primary underpinning principles for the resolution of ethical dilemmas in counselling and psychotherapy research design with respect for all participants. Point 3 of the framework itemises the following which shall be embodied by the T-E in the attempt to ethically develop knowledge from previously hidden processes in therapy and greater access to services for PPS:

- Respecting human rights and dignity
- Alleviating symptoms of personal distress and suffering
- Enhancing people's wellbeing and capabilities
- Improving the quality of relationships between people
- Increasing personal resilience and effectiveness

- Facilitating a sense of self that is meaningful to the person(s) concerned within their personal and cultural context
- Appreciating the variety of human experience and culture
- Protecting the safety of clients
- Ensuring the integrity of practitioner-client relationships
- Enhancing the quality of professional knowledge and its application
- Striving for the fair and adequate provision of services

In seeking to develop evaluation methods that minimise disruption to the therapy process the following ethical responsibilities (BACP, 2015, Point 5). were considered throughout the preparation in gaining ethical approval. These principles shall also be used to support the resolution of ethical dilemmas as they arise in practice:

- Being trustworthy: honouring the trust placed in the practitioner
- Autonomy: respect for the client's right to be self-governing
- Beneficence: a commitment to promoting the client's wellbeing
- Non-maleficence: a commitment to avoiding harm to the client
- Justice: the fair and impartial treatment of all clients and the provision of adequate services
- Self-respect: fostering the practitioner's self-knowledge, integrity and care for self

If an ethical dilemma is ‘strongly’ supported by at least one of the principles above without contradicting others, the BACP Ethical Framework (2015) suggests that such a decision is regarded as well-founded. As ethical decisions and dilemmas arise, the T-E will consider them in the light of these principles. However, there is a consideration within the framework of real-world dilemmas which raise complex ethical concerns, stating,

> A decision or course of action does not necessarily become unethical merely because it is controversial or because other practitioners would have reached different conclusions in similar circumstances. A practitioner’s obligation is to consider all the

> relevant circumstances with as much care as possible and to be appropriately accountable for decisions made
>
> (BACP, 2015, Point 7.)

As per guidance, the reasons for decision-making will be given.

Further to this, Preston-Shoot et al., (2008) argue the duty of care to maintain ethical research 'at the practice edge' particularly within organisations in flux, is an issue for research governance to ensure theoretical ethics is applied in action throughout the length of the research process. In the aftermath of participants giving informed consent to their personal sensitive data being analysed, reported on and published, further ethical issues may arise as identified within psychotherapy case studies by Edwards (2010) requiring continued attention to participant privacy. This requires vigilance throughout the evaluation and the meticulous anonymisation of data guided by the Information Commissioners Office (ICO, site accessed 5/8/2016). This shall reduce the possibility of any potential re-identification when the material is published (see further debate at 5.5).

Finally, the need for care of the individual researcher/evaluator is highlighted by Dickson-Swift et al., (2007) in their grounded theory analysis of the experience of researchers who are developing knowledge around sensitive subjects as they listen to 'untold-stories'. The T-E shall not only shall receive the support of regular clinical supervision but shall also seek personal therapy to reflect on any conflicts arising in the professional role of Therapist-Evaluator and its potential impact on the therapy intervention for the duration of the evaluation. The Methods Section seeks to promote the ethical standards (BACP, 2015) and to minimise risk to all participants.

5.3. Part 1: Service Evaluation in context

5.3.1. Evaluation questions: Part I

The evaluation questions stated below are within the legitimate remit of service evaluation in this relatively under-explored PPS phenomenon in naturalistic practice. The following questions shall be addressed through the quantitative ordinal and descriptive routinely collected service data:

1. How does the service demographic on mental wellbeing compare with other patient cohorts attending for healthcare interventions to improve wellbeing?
2. What is this service patient-cohort's experience of therapy?
3. What is the incidence and severity of persistent medically unexplained physical symptoms, over and above the presenting persistent sexual symptom?
4. What is the pattern found between the severity of symptoms and mental well-being in this patient cohort at baseline?
5. Is there a relationship between mental well-being and somatic symptom severity over time in therapy within the caseload of study?

The routine data collection methods across the service were used to answer the evaluation questions. These are outlined in greater detail in Part I (5.6.) of this chapter.

5.3.2. Case selection

This section defines the inclusions of the cases for in-depth examination to further clarify to whom the findings of the evaluation relate. These cases have been selected from the total patient referrals to the service. The main reason for patient referral to the service under evaluation is for persistent sexual 'dysfunction' of over six-months duration with the following criteria:

- not due to or wholly explained by medical condition
- not been diagnosed as an age-related condition

- not responded to routine medical care
- not recovered spontaneously over time
- not resolved by self-help

5.3.2.i. Case inclusions

- Aged over 18 and up to 64 as the recognized definition of ‘adult’ in the commonly used search engines such as MEDLINE, PsycINFO
- Referred to the specified Primary/Community Care Psychosexual Counselling Clinic by a registered healthcare professional
- Organic cause of the persistent sexual symptoms, if indicated, investigated by GP or Hospital Consultant prior to referral, or concurrently
- A minimum of a six-month history of persistent sexual symptoms not wholly explained by medical condition falling within the DSM 5 criteria for sexual symptoms codes 302.70 - 302.76, and 302.10 (APA, 2013), also see Appendix 2 Operational Definitions and Table 5.ii).

Table: 5.ii) Persistent Sexual Symptoms (PSS) inclusions

Sexual Symptoms by DSM-5 followed by ICD-10 coding ( )	
Male Erectile Disorder 302.72 (F52.21)	Female Orgasmic Disorder 302.73 (F52.31)
Delayed Ejaculation 302.74 (F52.32)	Early Ejaculation 302.75 (F52.4)
Female Sexual Interest/Arousal Disorder302.72 (F52.22)	Male Hypoactive Sexual Desire Disorder 302.71 (F52.0)
Genito-Pelvic Pain/Penetration Disorder302.76 (F52.6)	Unspecified Sexual Dysfunction 302.70 (52.9)

5.3.2.ii. Case Exclusions

In the exclusions, individuals who may be more vulnerable, or heavily influenced by concurrent circumstances, by severe mental illness or by learning challenges were identified, as seen in the list below. These exclusions are common with the primary research studies in Chapter 3. These conditions have been excluded because they render an analysis of the data and therapy transcripts more complex either due to communication issues or to current high emotional sensitivity.

Moreover, it is also important for this evaluation, that the therapist-evaluator (T-E) has direct communication with the participant by the use of common language in order to be able to develop an engagement with the patient and their PPS. Also, in these circumstances if a third party is used to interpret, it would not be known if the exploration of PPS is truly shared between patient and therapist. Additionally, those with a history of being unable to form satisfactory relationships may provide a similar challenge in developing common understanding. Therefore, the exclusions for the

depth therapy case studies to reduce risk of harm to the participants and a reduction in the quality of the data are as follow:

- Bereavement in the preceding six months of any person of close significance to the individual with grief disrupting usual day to day patterns of living and emotional responses
- Severe Eating Disorder disrupting daily living, diagnosed by GP and in early treatment or revealed through assessment and currently untreated
- Developmental (learning difficulties since birth) or Acquired Learning Challenges (traumatic or disease-related brain injury currently affecting cognition and emotional response)
- Recent psychotic episode diagnosed by GP or Mental Health Services. Medical record or self-reported suicide attempt within the preceding year of the evaluation
- Current Substance Addiction advised by medical record or self-reported on assessment
- Any individual requiring an interpreter for communication with the therapist
- History of being unable to form satisfactory relationships
- Medication induced sexual dysfunction

5.3.2.iii. Details of case selection

Case selection in this instance seeks as much variation in presenting cases as is usual in routine practice within the permissible inclusion criteria set for the evaluation. For the evaluation, the initial plan was to seek consent from all consecutive referrals to the particular T-E caseload. The period for selection was set for over two-months, for identifying cases that met the inclusion criteria until eight were engaged by fully informed consent, recognising the potential for participant drop-out.

This was to

- avoid bias in case selection by the Therapist-Evaluator
- give the fairest opportunity for participation
- collate the qualitative data from a 'normal' everyday work pattern

Widdowson (2012), McLeod (2012), Hersoug (2010), Kasper, Hill and Kivlighan (2008) provide illustrative examples of psychotherapy case selection within naturalistic settings. The case selection mirrors McLeod's (2012) consecutively referred psychotherapy case selection from her routine therapy practice of individuals with long-term physical conditions. It is observed that in the later analytic phase concerning the cross-case analyses, this type of selection facilitates an understanding of similarity and difference across the cases taken from the routine consecutive referrals that would normally be accepted into therapy.

5.4. Gaining ethical approval

The participants were selected from NHS Cambridgeshire Community Services (CCS), Luton Community Contraception and Sexual Health Services (Luton CaSH), of which the Psychosexual Counselling Clinic is a part. Cambridgeshire Community Services NHS Trust are the Therapist-Evaluator's sponsoring body. The Integrated Research Approval System (IRAS) Research/Evaluation advice sheet (Appendix 9) and the NHS Research and Development Forum Research/Evaluation underpinned the 'Evaluation' categorisation (Appendix 10) and therefore ethics approval via the IRAS was not required. The Trust's Research and Evaluation Governance panel led by the Medical Director gave ethical permission to the T-E's Evaluation Proposal; stating that the data gathering should not impact on the routine care of the participant. Appendix 8 shows the supporting letter of governance approval from the Medical Director Dr David Vickers, Cambridgeshire Community Services. Additionally, case selection was also dependent on the willingness of those who met the

selection criteria to consent to the anonymised-recording of therapy sessions (Part II, 5.8.1.) alongside their routine data collection, to be used specifically for the evaluation in building knowledge to improve interventions for future service users.

5.4.1. Public Participant Involvement (PPI)

In order to comply with the ethical principle of autonomy, clients must be in a position to give informed consent (Bond, 2004). This implies, that the client is in possession of relevant information and has the capacity to understand that information and its implications. For information collection, as mentioned in the ethical parameters (2.5.2), a protocol was devised through consultation for the ethical and most appropriate development of an informed consent procedure for the collection and processing of patient data. To ensure unbiased and actual information collection, it was important to minimise the disruption to routine practices and to give the individual a feeling of confidence and security within the every-day setting with the freedom to decline involvement. To support this, consultation on the participant paperwork was undertaken with the local Public Participant Involvement group. This was facilitated by the employing organsiation's research lead (PW).

Drafts of the Service Evaluation Information Sheet and Consent Form (see Appendix 7) were scrutinised by peer and academic discussions within the university research school, with the employer line manager and clinical team and by consultation with the Cambridgeshire Promoting Public Involvement in research group (PPI). The PPI suggested a title name change from 'Service Evaluation' to 'Service Review' as a more clearly understood, less challenging title for the study.

In the light of the information contained in the Research or Audit/Service Evaluation: IRAS advice sheet (Appendix 9) and the NHS Research and Development Forum (Appendix 10), this participant information and pathway to taking consent was approved by the Cambridgeshire

Community Services (CCS) Research and Evaluation Governance panel chaired by the Medical Director (see Appendix 8). The CCS NHS Trust Senior Research Fellow supported the journey to CCS NHST ethical approval.

5.5. Taking informed consent

The taking of a fully informed consent is questioned within psychiatry and psychotherapy disciplines due to the phenomenon of transference, of needing to please, out of fear of individual consequence and the impact upon current and future therapy (Levine and Stagno, 2001). The flow diagram (Fig. 5.1) was the result of an iterative consultation process and shows the process of obtaining informed consent to reduce as far as possible, the risk of coercion or regret. The resulting participant paperwork, the informed consent process and attention to maintaining minimal disruption to the routine therapy process (Appendix 3: Stage 2) allows the therapy to continue uninterrupted. Those consecutively referred individuals after completing routine baseline measures immediately prior to starting their therapy, shall be given the informed opportunity to participate in the Service Review (Appendix 7: Service Review Information Sheet and Consent Form). The protocol for taking consent is displayed as a flow chart (Fig. 5.1) as Stage 1 of Participant Experience (also found at Appendix 3). Stage 1* outlines the participant selection pathway during a 2-month period of all referrals to the clinic who meet the inclusion criteria: 'P' denotes 'Person' or 'Patient' who may or may not become the participant, and is inclusive of any gender, Therapist-Evaluator is 'T-E'. Those who agree to participate will be advised that if they change their mind, they can contact an alternative named person to decline involvement by telephone without having to give a reason. Equally they may sign and return an opt-out clause at the end of the consent form without having to give a reason. Once the withdrawal of consent is known, all paperwork and session recordings, coded and kept

securely and separately from the clinical record, shall be securely destroyed. In the case of consent withdrawal or regular renewed consent taken verbally at the start of each session, the therapy will continue as normal.

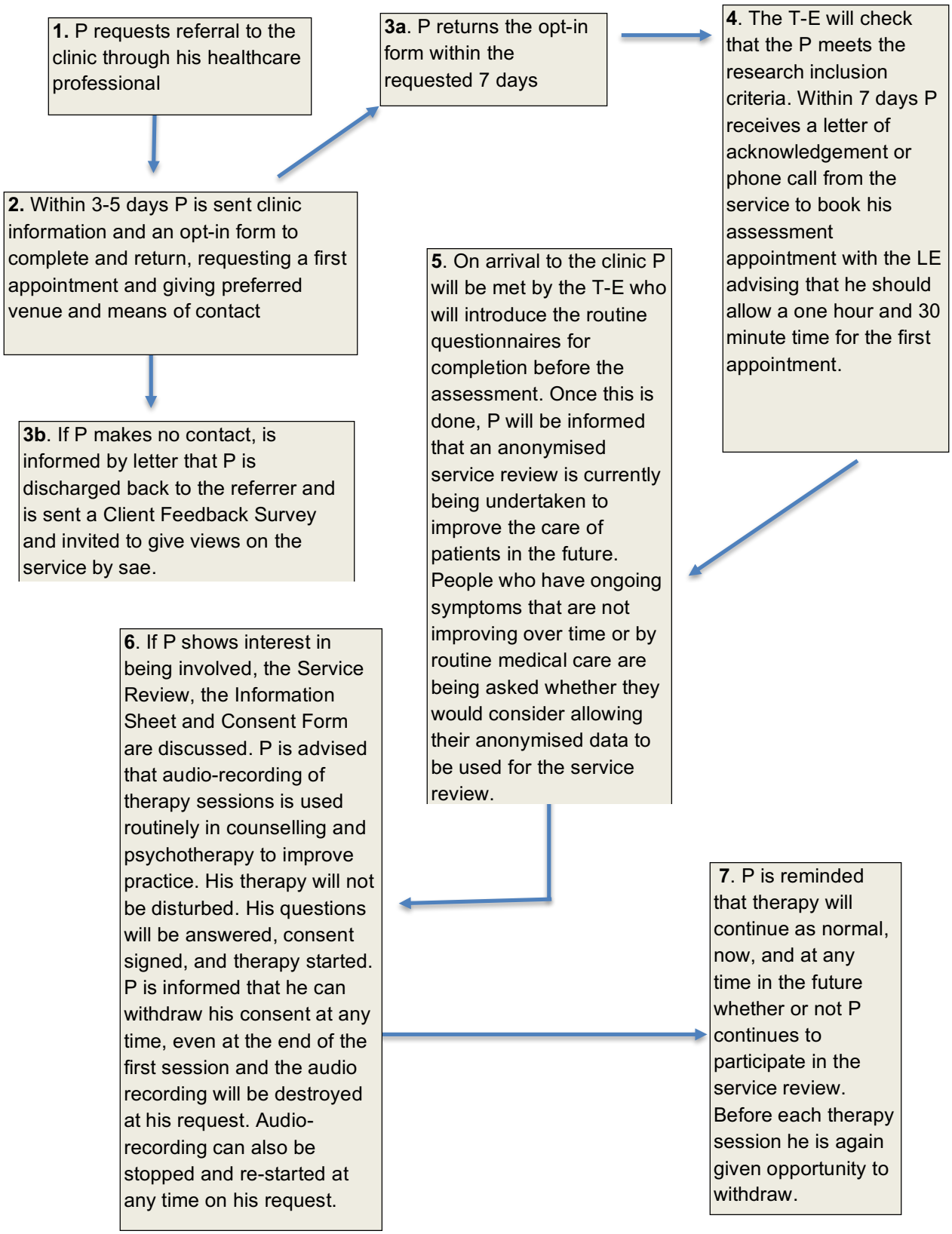

*Fig. 5.1 Flow chart patient experience in taking consent**

As stated, at the start of each therapy session the patient is asked again whether they are happy to continue to participate in the Service Review and are advised that the electronic recording can be stopped at any time. The participant shall be assured again that their therapy will not be affected in any way should they wish to decline, at any time, continued involvement in the review (Appendix 3, Stage 2. Participant Experience-Pathway during and after therapy). Thus, this flow chart shows serious attempt to minimise disruption through the length of routine therapy. Moreover, all participants, will have the freedom to generate an appointment with the T-E for any reason, for a six-month period following the end of therapy as is normal practice. Ethical issues concerning data storage the dissemination of results are addressed in the next section.

5.5.1. Anonymisation and storage of data

To re-iterate (from para 5.2.), Preston-Shoot et al., (2008) suggest the duty of care to maintain ethical research 'at the practice edge' is the responsibility of all stakeholders. In this instance the evaluation proposal is given local NHS ethical approval (Appendix 8) and ethical issues as they arise shall be addressed with the evaluation team (T-E and academic supervisors) over the period of the evaluation process and beyond to the future dissemination of results. The Participant Information Sheet and Participant Consent Form (Appendix 7) address the anonymisation and secure storage of patient data and outline how the findings will be disseminated and published in order to enhance professional knowledge and to improve practice with PPS of all kinds.

As previously cited, The Information Commissioners Office (ICO), England, highlights potential breaches of confidentiality in organisational and project data collation. The ICO guidance for anonymisation of data (ICO, 2012) discusses the definition of 'personal data' in the light of the English Parliament Data Protection Act (1998) as information which relates to a particular individual. The issue of lowering risk becomes one

concerned with the possibility or potential of re-identifying previously anonymised personal data (ICO, 2012, p.16). Whilst engaging with this issue of re-identification and examples of good practice (ICO, 2012, Annex 3), it becomes possible to appreciate how unintended, unconsented disclosure might occur, undermining the BACP Ethical Framework (2015). In order to minimise this risk the following care over data is taken to ensure confidentiality during the storage and analysis of findings (Appendix 6):

Data storage: Once the consent form is signed:

- any documentation relating to the participant will have their name replaced by an evaluation code
- the T-E will be the only individual who would have access to the details of participant name linked with their evaluation code in order to protect individual confidentiality
- this information will be kept separately and securely from the evaluation data to which only the T-E has access
- this link will be destroyed using an NHS shredding facility once the academic award has been achieved
- electronic audio-recordings of therapy will also be securely destroyed once the educational qualification has been achieved
- content of anonymised recordings will be transcribed under NHS Data Protection agreement and transferred back to the T-E to a password protected laptop
- selections of the anonymised data transcripts will be shared only by the permission of the T-E for analytic consultation and academic supervision
- those individuals who check any raw anonymised data as part of the analytic process within the academic setting, with permission of the T-E will have no means to link the data to the participants

The further ethical issue of the dissemination and publication of the evaluation findings are addressed in the following section (5.5.2).

5.5.2. Publication and dissemination of findings

The ICO Code of Practice for data anonymisation (ICO, 2012) suggests that if anonymisation is carried out thoroughly at the outset, considering the future possibility of data re-identification, the risks of breaking the UK Data Protection Act 1998 are minimised. It is suggested that organisations undertake Privacy Impact Assessments (PIA) (ICO, 2014) in order to put risk reduction measures in place and to publish a PIA for the public to be assured of organisational transparency of their personal data management (ICO, 2012, 2014). The T-E reflects this in the devised patient information and consent form, which is given by hand for future reference to the service review participants (Appendix 7). The following points are included:

- any personally identifying material will be removed from the reports
- informed consent for the publication of extracts of anonymised data is sought at the outset for educational and training purposes
- the participant may request to review the verbatim extracts
- the participant is offered a Service Review Summary Report

Finally, the BACP offers legal guidance for members to address potential breaches of confidentiality (Bond and Mitchels, 2014) in particular, concerning sensitive personal data. Sensitive personal data is defined as per Section 2 of the Data Protection Act 1998 as concerning a specific person, regarding racial or ethnic origin, political opinions, religious or other beliefs, trade union membership, physical or mental health condition, sexual life, criminality and criminal proceedings and outcomes. Working with theoretical guidance in addressing issues of consent with high regard for participant autonomy requires sensitive debate as argued by Levine and Stagno (2001). They noted critically, that Psychiatry as a medical discipline was not represented on the committee of medical journal editors

who met to agree to the publishing standards regarding individual consent to publication of potentially sensitive material. These publishing standards privileged participant autonomy over and above the need to enhance knowledge for clinical practice. Furthermore, Levine and Stagno (ibid., 2001) cite Vollman and Helmchen (1996) affirming that in psychiatry and psychotherapy practice, even with informed consent, the patient is not protected against the emotional consequences of publication. Moreover, the suggested good practice of sharing a sensitive case report with the individual who has consented, may in itself re-traumatise an individual. In some cases, even seeking informed consent to publication at any stage may be, because of personal vulnerability, unethical (Vollmann and Helmchen, 1996).

Through Levine and Stano's (2001) evaluation of the publishing guidance regarding consent to case study publication, of the three psychiatry journals selected, one suggested that without consent all personal identifiers should be removed and with consent, the patient should read the report first. The other two psychiatry journals did not include the patient reading of the account. Furthermore, no ultimate agreement is reached on the issue of combining cases or inventing case histories in order to avoid this ethical point of contention (Levine and Stagno, 2001). However, authors of sensitive research with subjects of reduced intellectual capacity due to severe brain injury show how the ethical dilemmas are carefully and creatively addressed to protect privacy within the specific context of the participants and their families (Saunders et al., 2015 a) and 2015 b).

For this evaluation, underpinned by the BACP Ethical Framework (2015) and legal guidance concerning confidentiality (Bond & Mitchels, 2015; DH, 2003: 35) the participants shall be asked for consent to publish anonymised verbatim extracts 'to develop a deeper understanding of how a patient and therapist engage with persistent physical symptoms during therapy', through presentations, teaching and educational publications

(Appendix 7, Consent to the use of therapy data for service review). Bond and Mitchels (2015) under their guiding definition of serious harm under English law, advise that, 'The prevention of psychological distress without other associated forms of (serious) harm is therefore best resolved by consent'.

To minimise potential participant distress over verbatim extracts used for dissemination and publication, the T-E shall thoroughly review the qualitative data to protect anonymity and facilitate participants to review any personal verbatim extracts should they request it (Appendix 7 Service Review Information Sheet). At the end of therapy, the participants shall be asked if they would like to receive a summary report of the service review, thanked for their participation and offered the routine six-month open-door facility for a self-generated review appointment with the T-E to discuss and address any matters arising.

5.6. Tools for data collection

I have observed over time in practice, that the opportunity for an exploration of PPS appears to emerge initially through the therapy relationship, rather than by applying, for example, a pre-set formula such as the 'Reattribution Model' developed by Morriss et al., (2007) to explain and manage the physical symptoms that trouble to the individual. This latter model, although it raises GP awareness and facilitates greater confidence in patient encounters, has not since been found efficacious in the reduction in severity of PPS or improved patient well-being (Duddu, 2008). This highlights the importance of scrutinising individual therapy sessions. The discovery of the unique context, how and to what effect the patient and therapist engage with and interpret PPS becomes possible using therapy transcripts of the live activity in therapy and from routinely used validated measures. Therapist structured post-session reflections and patient end-of-therapy feedback survey completion also support the analysis (Table 5.iii.).

Table 5.iii) Overview of Data Collection Methods

Data collected	Tools	Timing of data collection
Demographics and previous Mental Health interventions	Adapted CORE assessment form	On assessment
Digital audio-recording of therapy sessions	Informed consent protocol; Sony digital IC Recorder	From assessment to the end of the last therapy session
Therapy session transcription	Nuance Dragon Dictate 13 software	Familiarisation and full analysis after therapy end
Routine validated measures of physical symptom severity and well-being	*Warwick & Edinburgh Mental Well-Being Scale (WEMWBS), Patient Health Questionnaire-15 (PHQ-15)(Stewart-Brown et al.,2009)*	*Before assessment, before a mid-therapy session and end of therapy*
Goal Assessment	*Goal Assessment Form (University of Strathclyde) Likert Scale 1-7 on personal goal attainment*	*Joint development of goals and goal assessment score minimum x 2 during therapy*
Patient Feedback Questionnaire	*Service user satisfaction questionnaire (Penman, 2009) further adapted using aspects of the Porterbrook Clinic questionnaire (Wylie, Fitter & Bragg, 2009)*	*Completed in privacy: Given by hand at the end of the last therapy session or posted with sae within two weeks of end of therapy*
Experiential Session Forms parts I-III	Experiential Session Form (Elliott, 2002)	Completed by therapist after each therapy session to support analysis if needed
End of therapy data	Based on the CORE End of Therapy Form (coreimms.co.uk)	Therapist-Evaluator completed, end of therapy

5.6.1. Rationale for selection of routine service measures

On behalf of the British Association for Counselling and Psychotherapy, BACP, Roth (2010) attempts to answer the question whether counselling/psychotherapy outcomes can be truly measured. There are two diverse perspectives on these outcomes. On one hand outcomes are considered to be the product of the therapy relationship and are therefore unique and cannot be compared across cases. On the other hand, there is an acknowledgement that the individual who comes into therapy is not only seeking self-understanding but also looking for change. This change may be experienced in physical and emotional symptoms and improved relationships.

My own assumption in the use of measures is that although measurement of changes is subjective and need to be understood in context, change measures may give a partial perspective on change across a particular cohort. And this assumption has been validated for use in particular populations by statistical research methods. Change in this instance shall be further understood by the inclusion of qualitative data from the individual's therapy and their evaluation of personal goals during and at the end of therapy.

It is noteworthy, that even without qualitative material, Lambert's study (Lambert et al., 2001) gives evidence that individuals, whose therapists receive feedback on progress through measures taken during therapy, will attend more sessions of the counselling contract. Also these individuals will have improved outcomes than when measures are not used nor brought into the therapy for discussion between therapist and patient. However, the Sex Therapy Measures Outcomes Project (STOMP) phase 1 evaluation of measures and outcomes (Twigg and Mellor-Clark, 2013) supported by the College of Sex and Relationship Therapists (COSRT), Relate UK, the CORE IMS and the Artemis Trust, noted the range of patterns in staying in therapy when referred or self-referred for

psychosexual therapy. Twigg and Mellor-Clark (2013) recommend that as there might be assessment only, early ending or therapy completion:

- all these types of engagement need distinct outcomes methodologies
- it cannot be assumed that one measure fits all
- an acknowledgement of the value of the outcomes of personal goals alongside validated measures of change
- to select fewer variables and use of the least onerous scales

Lucock and colleagues (Lucock et al., 2003) examine practice-based evidence in the context of service evaluation. They argue that systematic assessment of change is worthwhile in the world of public service and health care. Reflecting the findings of Lambert et al. (2001), Lucock also confirms from practice, that the reflective practitioner is able to re-focus his skills with the application of the immediate feedback of measures, as required to meet the particular needs of the patient as they arise. In support of this realist approach to service evaluation design, Lucock's service evaluation study recommends adding qualitative approaches and reflective practice to quantitative data generation.

5.6.1.i. Considering measures

Measures used in primary research on this topic were scrutinised for applicability to this specific patient group. Mellor-Clark and Jenkins in 2001 set up the Core Information Management Systems (CORE IMMS). CORE IMMS as a group has developed and refined the set of CORE routine evaluation and therapist assessment measures for counselling and psychotherapy in primary care settings. This routine evaluation initiative was underpinned by the work of Barkham et al., (1998) in order to facilitate a reduction of the research-practice gap, which has been referred to in Chapters 1 and 2. The self-report outcome measure (CORE-OM) and the therapist completed assessment form (CORE-A) have been comparison checked across primary and secondary care settings. Good discrimination

between service settings and their patient populations were reported (Barkham et al., 2005). These measures are found in the primary studies of short-term psychotherapy for PPS (Mayor et al., 2010; Guthrie et al. 2004; Payne and Stott, 2010, see Chapter 4).

Nevertheless, having worked as a primary care counsellor for many years, the questions relating to mental well-being used by CORE-OM are, to a degree, by negative mental health language terms such as, 'I have thought it would be better if I were dead', 'I have been physically violent to others'. These statements are balanced by others such as, 'I have been able to cope when things go wrong' and 'I have felt I have had someone to turn to for support' and together, can be related to by the majority of those referred to generic counselling in Primary Care. Equally, the Patient Health Questionnaire, PHQ-9 (Spitzer et al., 1999) that alerts to depression and the Generalised Anxiety Disorder, GAD-7, although quick and easy to use, are primarily for the evaluation of the most common mental disorders. This primary care counselling cohort (now seen within IAPT, UK services) are very well-aware of their personal distress. For PPS sufferers, and for those attending the Psychosexual Counselling Service, stressors may be found only on engagement with the individual, below the level of conscious awareness and therefore, this kind of stress would not necessarily be self-recorded in the CORE-OM.

When reviewing validated measures for the Psychosexual Counselling Service in 2013, these measures seemed incongruent, especially for the individuals referred who are looking for help with sexual dysfunction. The CORE-OM research team at the time were developing and piloting an outcome measure for psychosexual therapy (PST), in the form of the Sex Therapy Outcomes Measure Project (STOMP).

It was also observed that the nuances of change experienced by the individual or couple and the attempts to measure change were not always captured and completion of the STOMP data sets were challenging, thus

severely reducing the final numbers for the analysis of outcomes (Twigg and Mellor-Clark, 2013). Therefore, we see the attempts by members of the College of Sex and Relationship Therapists (COSRT) with the National Sexology Outcomes Group (NSOG) to create a universal outcome measure for PST to continue.

5.6.1.ii. Selecting somatic symptom measures

To facilitate the capture of Practice-Based Evidence (PBE) in the context of service delivery, the outcome measures of physical symptom severity used in the primary studies of the literature review (Appendix 12, Table C) were further considered for use in this service setting. Within the parameters of these considerations, it had to be taken into account that the clinic population is not in need of gross motor rehabilitation, such as being able to walk upstairs or bathe, nor are they necessarily depressed or suffering from anxiety, although some are.

The PSCS needed an easy method to complete brief somatic symptom measure that included reference to sexual difficulty, and a well-being scale with the use of positive mental health language terms. This ruled out the use of the thirty-six item Short Form health survey, (SF-36) which does not focus specifically on medically unexplained symptoms nor on sexual difficulties (Stewart and Ware, 1992; Ware and Sherbourne, 1992). Also use of the Illness Perception Questionnaire (IPQ) Somatic Symptom Scale which indicates 12 bodily symptoms with again, no mention of sexual difficulty (Weinman et al., 1996) was ruled out. Further, the scale of Health Related Quality of Life relates more to disease, injury and treatment recovery (Ware et al.,1992). The Global Assessment of Function, a one-hundred-point scale (Jones et al., 1995) and the Somatisation Scale of the Symptom checklist, SCL-90-R (Derogatis, 1994) exclude the majority of ‘medically unexplained’ physical symptoms (Rief and Hiller, 2003).

Rief and Hiller (ibid., 2003) suggested and put under trial a development of the screening tool for somatoform symptoms, SOMS, (Rief et al.,1995) noting also that the World Health Organisation's (WHO) somatic symptom screening checklist was not created to measure change (Isaac et al., 1995). The developed SOMS-7 for screening and change was shown to be valid and a reliable measure for change in frequency and severity of PPS. However, the authors noted at the time that mild and moderate cases found in primary care and out-patient settings were under-represented and further work was needed to shorten the measure for its use in primary care and for mild to moderate sufferers of PPS.

One Portuguese study by Fabião et al. (2010) with Rief's involvement found their shortened version of SOMS-2 from 53 items to 29, as version R-SOMS-2, when PPS was particularly related to anxiety and depression, was a valid tool indicating the need for further specialist intervention. In future, for research into interventions for PPS in primary care, the original full SOMS-7 53 items, (see Rief and Hiller, 2003, Table 5.iv) may be useful in comparing and contrasting specific primary and acute care interventions for the mild to severe PPS population. However, this scale was found to be too extensive to use in routine practice within the Psychosexual Counselling Service.

Table: 5.iv) Justification for the de-selection of measures of physical symptom change

Measure and reference	Reasons excluded for use in the service evaluation
Short Form health survey (SF-36) (Stewart and Ware, 1992; Ware and Sherbourne, 1992),	No specific focus on persistent medically unexplained symptoms (PMUS) and cost implications
Illness Perception Questionnaire (IPQ) Somatic Symptom Scale (Weinman et al., 1996)	Measures 12 bodily symptoms but no measure of sexual symptoms
Health Related Quality of Life, HRQoL (Ware and Sherbourne, 1992)	Relates more to disease, illness and treatment recovery and no mention of sexual symptoms
Global Assessment of Function, GAF (Jones et al., 1995)	Used particularly for psychological disturbance and for severe mental health conditions, not suited to our population
Somatisation Scale of the Symptom checklist, SCL-90-R (Derogatis, 1994)	Excludes the majority of medically unexplained physical symptoms
Screening for Somatoform Symptoms-7 (Rief and Hiller, 2003)	Could be useful for future research comparing change in acute and primary care populations

The exploration above led to the consideration of The Patient-Health Questionnaire, PHQ-15 (Kroenke et al., 2002). It is a simple measure that is completed in under five minutes and is used in studies examining persistent medically unexplained and medically explained persistent physical symptom (PPS) outcomes (Mayor et al., 2010; Creed, 2011) and

for the exploration of the positive language Warwick and Edinburgh Mental Well-Being Measure, WEMWBS (Stewart-Brown et. al., 2009).

5.6.2. The Patient-Health Questionnaire

The Patient-Health Questionnaire, PHQ-15 was developed from the Primary Care Evaluation of Mental Disorders (PRIME-MD) and the PRIME-MD Patient Health Questionnaire (PHQ) (Kroenke et al., 2002). It has been reported by Korber et al., (2011) to be a valuable and moderately reliable tool for detecting and monitoring somatic symptom severity in clinical practice and research. This questionnaire can be used, alongside clinical judgment, as a simple measure to pick up any persistent physical symptoms, including 'sexual pain or problems during sexual intercourse' and the level of severity for the individual in Primary Care. In this measure, the individual marks by the list of physical symptoms, over the previous 4 weeks 'not bothered at all', 'bothered a little' or 'bothered a lot' (Appendix 5, PHQ-15 scale).

As we began to use this measure in practice, we noted that at times the 'sexual pain or problems during intercourse' during the last four weeks were ticked as 'not bothered at all', even though this may have been the reason for referral to the service. Of those individuals asked why this was not filled in, all said that it was because they had not tried intercourse in the last 4 weeks and so felt that they were 'not bothered at all' in terms of the wording of the questionnaire.

Moreover, in the questionnaire, two further categorisations of 'sexual problem' were considered as lacking for our service:

- Loss of interest in sex
- Difficulty in becoming sexually aroused (e.g. difficulty with erection, lack of lubrication or lack of sensation)

These were added as an extra to make the questionnaire an all-inclusive measure, to the end of the PHQ-15 list of symptoms as number 16 and 17

respectively and added to the scoring final as a plus number (ie PHQ-15 score + score from the extra two questions). This was undertaken for the routine service evaluation so as not to disturb the validity of the PHQ-15. These last 2 question responses have not been used for this service review as they need further evaluation in the future. This PHQ-15 scale is currently completed by the individuals as part of usual therapy immediately before assessment, mid-way and end of therapy before the start of each of these therapy sessions. This is not for the diagnosis of PPS, but to observe for physical symptoms that may indicate somatisation and to observe for severity change through therapy.

5.6.3. The Warwick and Edinburgh Mental Well-Being Measure

The WEMWBS scale was originally developed as a measure of mental wellbeing by NHS Health Scotland within the Mental Health Indicators Programme. Professor of Public Health, Stewart-Brown and Academic Clinical Fellow Janmohamed give an overview in the WEMWBS User Guide (Putz et al., 2012).

During the therapy an assessment of mental wellbeing is gathered routinely at the same time as the PHQ-15 gives information on somatic symptoms. This offers context regarding self-perceived wellbeing through the positive mental health language of the Warwick and Edinburgh Mental Well-Being Measure, WEMWBS (Stewart-Brown et al., 2009) before, approximately half-way and at the end of therapy (see Appendix 5 WEMWBS format). This measure was selected, because it was observed that the participant cohort being studied did not look for help with anxiety and depression at the time of their presentation for referral to the service, although if this were found, a GP consultation would be recommended. The WEMWBS has been found well-suited to general population samples. A response to 14 items by a 1-5 Likert Scale (Likert, 1932) is a straightforward, acceptable tool and easy to complete in under five minutes. Moreover, the WEMWBS is recommended by the UK,

Government paper, ‘No Health without Mental Health’ (DH, 2011a) as a ‘well-evidenced example for measuring adult mental well-being’ (para 1.85) used in the North-West Mental Well-Being Survey (Deacon et al., 2009). The Health Survey for England now includes the scale.

Since 2009 the WEMWBS has been tested for responsiveness at individual and group level and found to be responsive to changes through mental health interventions in different populations. Maheswaran et al. (2012) note its responsiveness in nine out of twelve studies. Additionally, the scale was also found responsive in studies undertaken with people with or without mental health problems and was able to detect subtle improvements. The guidance of the Maheswaran et al., (2012) paper will be referred to during the individual data analysis of the WEMWBS findings (6.5).

In a study of the validity of the scale in Chinese and Pakistani communities in the UK, Taggart et al. (2013) found in the WEMWBS high levels of reliability and consistency are well-suited across populations in the UK. Stewart-Brown et al., (2009) discuss the potential of shortening the scale, but at the time suggested that the full scale be used for research purposes. Also, the full 14 items WEMWBS is now used within the service for the evaluation. The use of the scale has been registered with Professor Stewart-Brown.

5.6.4. CORE therapy assessment form for demographics

The CORE Therapy Assessment Form gave a good structure for gathering demographic data for the purposes of the service evaluation that is related to the depth cases. This helps to align the population against other research/evaluations in healthcare settings. Barkham et al., (2010) suggest a minimal data set as the grounding for practice evaluation to include demographics, client and therapist backgrounds, such as gender, age, educational background, ethnicity, therapy modality, experience level as therapist, previous therapy experience as patient and presenting problems.

The Lead Evaluator collated the demographics of the participants at the time of the initial therapy assessment. The main elements of the CORE-Therapy Assessment Form(Core Systems Trust) were used:

- age
- sex
- employment
- ethnic origin
- living conditions/relationships
- previous MH interventions
- current medication for mental health problems
- individual's identified problems or concerns and therapist severity rating (therapist rating from 1 'minimal', to 4 'severe')
- risk assessment (therapist rating 'none, mild, moderate or severe')
- what the person has done to cope with or avoid their problems

For the purposes of the evaluation the following are added:

- length of history of the most prominent PPS
- all current prescribed medications, reasons for the prescription, length of time taken

The routine service end of therapy Client Feedback Survey is discussed later in this Data Collection section (5.6.6).

5.6.5. Goal Assessment Form (GAF)

As discussed in Chapter 1, good outcome therapy is now known overall to be more dependent on client factors (70%) than on any other (Cooper, 2008; 2012). These shall be observed during the study, as the therapy progresses. However, goal consensus and collaboration, have been shown as demonstrably important to quality outcomes (Norcross, 2002) and will be measured by the Goal Assessment Form (GAF), which has been developed by the University of Strathclyde and is now used within the routine therapy interventions with personal goals developed during the therapy between the patient and therapist. Once realistic goals have been defined and agreed by patient and therapist, the GAF is completed, if possible, in the patient's own words. Progress is measured by patient rating of the GAF by Likert Scale 1-7 at least twice, once during and once at the end of therapy as a within-session element of the therapy process (Appendix 5.).

5.6.6. Client Feedback Survey (CFS)

The format of the service feedback has been under continuous development and has evolved over the last 10 years (Penman, 2009). In 2013 the form was further adapted using material from the Porterbrook Clinic, Sheffield end of therapy questionnaire (Wylie et al., 2009). Likert scale from 1-7 assesses patient perspective:

- How would you rate the trouble, worry or distress your problem(s) caused you when you first came to our clinic?
- How would you rate the trouble, worry or distress your problem(s) cause you now?
- How satisfied are you with your ability to handle the problems(s) that brought you to therapy?

This is followed by a therapist alliance question:

- How satisfied are you with your therapist in relation to

a) Understanding your problems
b) Caring and warmth
c) Respect for your opinions and feelings
d) Knowledge in the special area of sexuality
e) Flexibility with appointments
f) Promptness

And two final Likert scales seek to understand the overall satisfaction of the individual under therapy with the service and whether they would recommend the service to family and friends.

At the end of therapy, all patients are given an opportunity to provide their feedback using the questionnaire. The service 'Client Feedback Survey' is made available individually by hand at the last therapy session or sent by post. In either case, the survey form is to be completed in privacy and returned immediately in a sealed envelope to the reception desk or to the service administrator within the following 3-4 days. The latest service survey form is found at Appendix I. Certain questions of the survey, which are shown above have been particularly extracted from the survey as their answers are integral to the data collection.

The table below (Table 5. v) shows the currently used routine practice-based measures within the service and the timings of use within therapy. These form the ordinal measures of change of the intervention.

Table 5. v) Routine Data Collection using validated measures

Type of Data	Format	Baseline	Mid-therapy	End-therapy
Demographics inclusive of medications	*CORE Therapy Assessment Form* (coreimms.co.uk)	✓		
Somatic Symptoms	*Patient Health Questionnaire PHQ-15. (Korber et al., 2011)*	✓	✓	✓
Well-Being	*WEMWBS (Stewart-Brown, Tennant et al., 2009)*	✓	✓	✓
Goal Assessment	*Goal Assessment Form (University of Strathclyde)*		✓	✓
End of Therapy Feedback	*Client Feedback Form (adapted 2013 with reference to Wylie et al.,2009 by J. Penman and team)*			✓

5.7. Proposed analysis of quantitative data

Whole service data from April 2014 to March 2015 has been considered to provide the wider context of the realist service evaluation (n=178, n=181). Service demographics follow Creed (2011) study of the relationship between somatic symptoms, health anxiety and outcome. The quantitative data analysis shall be undertaken as follows (Chapter 6) with other service comparisons given where possible:

Across the service population

- Baseline service demographics, reason for referral, length of symptom history
- Baseline incidence of persistent sexual symptom (PPS) severity and mental wellbeing
- Baseline incidence of other somatic symptoms
- DNA first appointments

Across the selected caseload

- The relationship between mental well-being and the severity of somatic symptoms over time

Within-Service main caseload comparison of outcomes

- Examination of exceptions

Whole service survey

- The user experience of service delivery and subjective change

Latterly, across the four depth cases (Chapter 8.7)

- The nature of personal goals for therapy
- The achievement of personal goals for therapy
- Case-level Wellbeing and Somatic Symptom scores

5.7.1. Analysis of quantitative measures

Convergence of data by triangulation is not necessarily anticipated in realist evaluation (Pawson, 2006). Whatever may be the analytic findings of the quantitative data, the therapist session reflections case by case and the subjective patient therapy evaluations broaden and deepen an understanding of unifying themes and complexity in evaluating the exploration of PPS in practice. This is discussed in in greater depth in Chapter 9. Business researchers Dubois and Gadde (2002) suggest welcoming the concepts of paradox and contradiction as these help to avoid simplistic conclusions and open the eyes to areas for further investigation.

For this analysis, a simple percentage is used on the service cohort. In the study, data was available for demographics, referral reason and length of symptom history (n=181) displayed as bar charts. The severity rating of persistent physical symptoms are shown as ordered categorical data as 'none, mild, moderate, severe'. The Likert scaling change of the Client Feedback Survey (CFS) is presented as percentage (n=89) of all returns representing 50% of 178 service-users within the period of study. Also, goal assessment change on the four selected cases is presented (8.7.1) in context of Likert points of change.

5.8. PART II: Therapy process data collection and analysis

Qualitative data has been gathered from the transcripts of audio-recorded therapy sessions, which were conducted on taking consent from the participant for the four whole therapies. One of the guiding principles of service evaluation as outlined by Robson (2011) (Chapter 2.4) is feasibility of completion within the given time frame. Thus, to comply with this, some adjustment to the quantity of qualitative analysis had to be made.

In response to the aims and objectives of the study, Aim 3 (Chapter 1.1.), the examination of the transcripts of four consecutively referred cases of therapy were used to identify and explore the questions of:

- the predisposing, precipitating and perpetuating factors of the PPS
- how the therapist and patient engage with the PPS and to what effect

5.8.1. Audio-recording of therapy sessions, evaluation governance

For many years, audio-taping of therapy sessions that may be taken by oral or written consent from the patient or client has been practiced as an acceptable means of examining and enhancing clinical skills. Moreover, samples of recordings are known to be used in case supervision. Audio or video-recording is now governed by counselling and psychotherapy and medical professional bodies (BACP, 2010, G14; General Medical Council, GMC, 2011). In this instance, the study of the therapist and patient-in-action, is validated by two senior researchers over the whole the course of therapy. Recording of therapy sessions allows practice in situ to be systematically examined and evaluated in relation to the challenges of addressing PPS for patient benefit.

Additionally, in context of evaluation evidence, the British Association for Counselling and Psychotherapy, BACP Advice sheet G14 (2010) by Lawton makes the following points:

- Evaluation evidence may not directly benefit the client whose session was recorded, but could increase knowledge and understandings that might ultimately benefit many clients in the future
- The values of counselling and psychotherapy include a commitment to ‘enhancing the quality of professional knowledge and its application’ (BACP, 2010: 2)

To ensure ethical confidentiality and protect patient privacy rights, the encrypted digital recordings, identified only by a unique research code

shall be sent password protected via the University Drop Box facility to a doctoral research student employed by Cambridgeshire Community Services, an NHS experienced service administrator and a senior data analyst who shall support the transcription of the data. The transcriptions shall be returned securely. The key to the research codes shall be accessible only to the therapist-evaluator (T-E) and kept separately and securely from other records. The transcriptions and therapist reflections shall be kept securely and separately from the case notes, in preparation for analysis.

5.9. Structured Reflexivity

The reflexive methods for this insider-Realist Service Evaluation are shown as a pathway illustrating the layers of reflexivity which shall be applied to the whole evaluation process (Fig. 5.2.). It begins with the reflexive statement of the Therapist-Evaluator position of professional training, experience and conceptualisation of PPS laying a transparent foundation for the situation and role of the therapist as insider-evaluator. Rolfe's reflexive cycle and his defined types of reflexivity as discussed (Chapter 2.6.3) shall provide an uncomplicated, easily accessible means of developing a transparent account of the process of this reflexive insider-Realist Service Evaluation, again in particular relation to the role as Therapist-Evaluator (T-E) and analytic decision-making. The therapist reflection after each therapy session using Elliott's Experiential Session Form (5.9.1) and regular psychotherapy case supervision is enhanced by the simplicity of Freshwater and Rolfe's (2001) definition of reflexivity concerning in and after the event.

5.9.1. Experiential Session Form

In order to keep a structured written and reflective record of the therapy sessions, extra to routine clinical case notes, the work of a group of experiential therapy clinician-researchers recommends the use of the Experiential Session Form devised by Elliott (2002). This is shortened to the use of sections I-III (see Appendix 5). This covers

a) therapist observations and reflections
b) overall therapist session ratings as helpful or hindering using a Likert Scale
c) identification of the individual's in-therapy mode of engagement

This form shall be used as contextualising background material only, for reflexive purposes for the therapy itself and the routine professionals case supervision and to support the final analysis of within-case measures if required.

5.9.2. Reflexive analytic decision-making

The use of reflexive memos have become a part of the process of the analysis of qualitative data and decision making for data coding and the final distillation of themes (Ritchie et al., 2003) and are described in Chapter 7. Figure 5.2. shows the further layer of reflexive analysis which shall be used to examine the progress and direction of the therapy engagement and to discern how the impact of predisposing and perpetuating mechanisms of PPS are disabled.

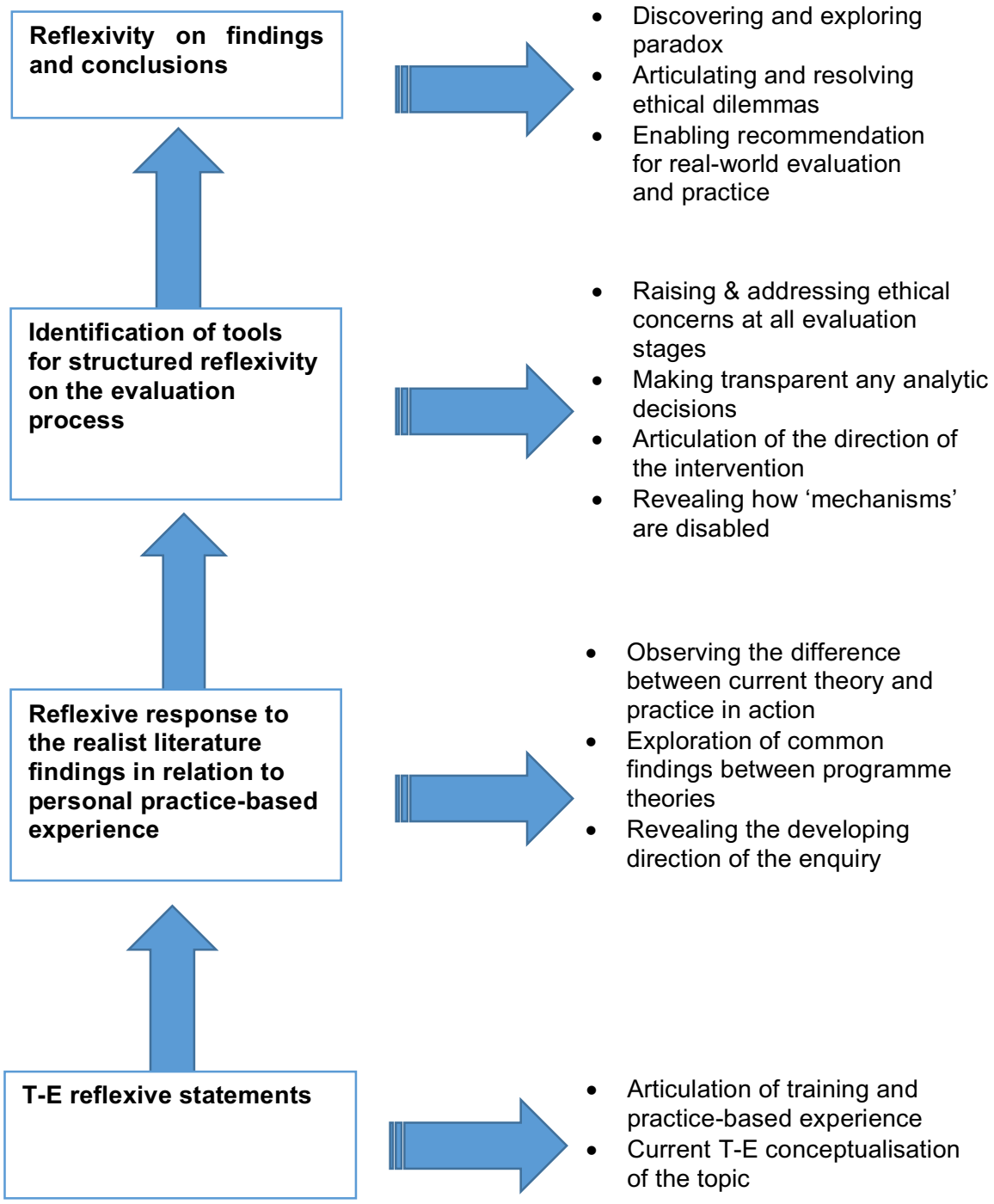

Fig. 5.2. Reflexivity: Potential outcomes

5.10. Developing the Analytic Protocol

Embedded into its context, the analysis is responsive to the requirements of realist evaluation and is designed to explore how the intervention may or may not, have disabled the mechanism responsible for the original problem (Pawson and Tilley, 1997). However, in Realist Evaluation a 'mechanism' is not the intervention itself but is a theory that provides account of the content of the interrelationships within and on the delivery of the intervention, leading to outcomes (Wong et al., 2013). The study of how the 'autopoetic mechanism' in PPS (discussed at 1.3.1) i.e. how the perpetuation of persistent physical symptoms is dismantled is highlighted as one of the research recommendations of Deary et al., (2007) The analytic protocol is devised to facilitate the exploration of how and to what effect the patient and therapist engage with PPS.

5.10.1. An abductive approach to qualitative data analysis

An 'Abductive Approach' to data analysis within realist evaluation research, is said by Robson to enable a critique of the value or worth of a real world intervention (2011). A coding framework can be devised in advance of qualitative data analysis (Tuckett, 2005). The analytic coding is a purposeful aspect of knowledge development within the realist evaluation. Practice-based evidence and theoretical perspectives are used in this instance, to assist the evaluator to develop conceptions of 'how' the patient and therapist grow their exploration and disable the perpetuating mechanisms of the persistent physical symptom. This process serves to widen theoretical links between CBT and STPP interventions for PPS, thus moving towards the recommendation to examine multimodal interventions and process (Deary et al., 2007).

As opposed to a 'tight and pre-structured' frame of a deductive analysis, or in favour of a 'loose and evolving' inductive analysis, Dubois and Gadde (2002) bring a useful account from the business world, of the principles of

data analysis by abduction. Dubois and Gadde in effect illustrate the difference between abduction for theory construction as is outlined by Tavory and Timmermans, (2014) and an abductive approach, which does not create or confirm but enables a 'tight and evolving' framework by which to enhance theory already in existence. As observed previously, the question of 'how' or 'process' is rarely answered by 'evidence-based' interventions. The following table summarising Dubois and Gadde (2002) itemises the essential ingredients by which to analyse the data by abduction:

- Systematic combining of data within the analysis: tight and evolving
- A tight articulation of pre-conceptions
- A preliminary analytical framework
- Matching theory to reality and vice versa
- From the empirical evidence in relation to literature, showing evolving framework of what has been learnt
- Building on theory rather than theory generation or testing

5.10.2. Developing the preliminary analytical framework

For the service evaluation, as stated above, an abductive, rather than inductive (starting without theory) or deductive (comparing data with a set of assumptions based on one theory) is used. The abductive analysis is undertaken to ensure that the data populates a preliminary analytic framework based on representative current theories of CBT and STPP for conceptualising and addressing PPS as follow in the next section. Data is systematically and cyclically checked with the pre-selected prevailing theory and exceptions noted. The preliminary analytical framework is outlined.

5.10.2.i) Theoretical underpinning

Through the cycles of exploration into the literature surrounding the phenomenon of persistent physical symptoms I personally recognised that I had adapted my use of brief psychodynamic principles to the presenting needs of the patient by the judicious use of occasional behavioural interventions. Moreover, as stated, the literature also provides evidence that primary research into interventions for PPS show some indication of common factors in the amplifications of therapy across STPP and CBT modalities. It was a challenge to find a diagrammatic representation of a brief psychodynamic intervention for addressing PPS in practice, expressing a distillation of principles, that could be grasped equally by the CBT as the STPP practitioner. A brief summary of STPP and CBT perspectives on PPS interventions is presented from which the preliminary analytic framework for qualitative data of this study is formulated.

5.10.2.ii) Selection of theoretical principles

The selection of theoretical principles for engagement with PPS emerge from practice and evidence-based Brief or Short-term Psychodynamic Psychotherapies (STPP) and Cognitive Behavioural Therapies (CBT) for PPS.

Brief psychodynamic psychotherapy (PP) is not considered to be a short version of long term PP, but rather includes the basic principles of psychodynamic approaches. It is acknowledged as a time limited approach, which agrees and maintains a specific focus for the therapy. It is not necessarily intended to 'cure' but to begin a process of change that continues into the future (Levenson, 2010).

For the sake of accessibility and for the purposes of this study, Shedler's seven core techniques (2010), (Appendix 2-Psychodynamic Principles) is described here. This approach represents the core constituents recognised within the types of STPP interventions utilised for interventions

with PPS within the studies found. Additionally, a psychodynamic focus along with the requirement within a brief PP of agreeing and maintaining a specific focus for the therapy is itemised below:

- Focus on feelings and expression of emotion
- Exploration of attempts to avoid distressing thoughts and feelings
- Identifying recurring themes and patterns
- Discussion of past developmental experiences and how these shed light on current coping
- Focus on interpersonal relations in terms of understanding patterns of meeting, or not meeting, emotional needs
- Focus on the therapy relationship as a live example of patterns of relating
- Given the opportunity to explore desires, fears, and fantasies

(Adapted from Shedler, 2010)

All versions of STPP for PPS that are found in the primary research studies contain the elements above.

The recommendations of Woolfolk and Allen for CBT for PPS are selected due to their extensive exegesis of treating somatisation using an affective CBT approach (ACBT) (2007). This is considered within the broader background of a CBT model that hypothesises an autopoietic cycle of symptom maintenance (Deary et al., 2007, see Appendix 17).

Woolfolk and Allen (2007, 2010), who are the developers of Affective Cognitive Behavioural Therapy (ACBT) recommend ways of experiencing within therapy. They also add that these experiences, in their view, are needed as CBT practitioners attempt to address persistent physical symptoms or 'somatisation'. They borrow ways of working on the expression and differentiation of emotion from the Experiential Therapies, to expand the CBT practitioner's frame of reference when addressing PPS in practice. The broad areas of focus when addressing PPS by ACBT are

outlined as engaging within a biopsychosocial perspective by the following approaches:

- interpersonal
- cognitive
- behavioural

addressing aspects of PPS with

- emphasis on emotional processing (with reference to the Experiential Therapies)

A CBT practitioner is alerted by the research and writings of Woolfolk and Allen to more effective ways of addressing somatisation in practice. In particular, by the recommendation to adopt the principles of approaches to emotion of the Experiential Therapies underpinned by the theorists as identified below. It is noteworthy, that Woolfolk and Allen (2010) observed treatment sessions using the emotion-focused therapy of Greenberg and Watson (2005), and McCullough et al., (2003) with a combination of psychodynamic and behavioural approaches in the treatment of 'affect-phobia'. This they found to be very similar to their own work with affect within ACBT.

In the Handbook of Experiential Psychotherapies on history and theory, Greenberg et al, (1998) have related experiential psychotherapy to some of the following theorists. Those itemised in the following table have a degree of relationship to interventions for PPS within the research literature. (See Table 5. vi).

Table 5. vi) Theoretical underpinning for experiential psychotherapies
Selected from Greenberg et al.(1998)

Theorists	**Core understandings utilised in practice by the experiential therapist**
A. Rogers (1979)	When a repressed feeling is fully expressed with acceptance within the therapist–patient relationship it is a non-linear process. There is a felt psychological shift and physiological change related to newly developed insights. Humans actively process and organise information whether by conscious thought or by means below the level of consciousness.
B. Bohart (1993); Watson, Greenberg and Lietaer (1998)	Stimulating by empathy, reflection and exploratory responses, evocative language and use of metaphor and symbol to capture the significance of previous experiences.
C. Rennie (1992); Watson et al. (1998)	Sensitive attunement: making only tentative interpretive suggestions and creating the opportunity for the individual to disagree.
D. Gendlin (1981) and Rogers' (1961) definitions of emotion and feeling	Emotions = the physical sensations or responsive reactions to the environment; Feelings = interaction of cognition and emotion
E. Watson et al., (1998, Ch 1.)	Using these experiential techniques above to develop and maintain the therapeutic relationship and to facilitate within-session experiencing of emotion and the cognition of feeling and its relationship to events: a balance of responsiveness and facilitation.

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5.10.3. The discovery of links between third generation therapies

The elements that are outlined in the Experiential Therapy perspective relate to emotion (Table 5.vi) and are in common within the work of psychoanalyst Balint (1957). These elements are also used as interventions for PPS in the primary research studies of short-term psychodynamic therapies as discussed in Chapter 4.

Clinical Psychologist Levenson shows a historical link from the psychodynamic to the experiential therapies, thus revealing an evidence that therapists from a classically psychodynamic perspective, more recently appear to align themselves to the experiential psychotherapies (Levenson, 2010). Moreover, proactively facilitating emotion and its unique cognition is also found to underpin, the early work of psychoanalysts Malan (1963) and Davanloo (1980) in developing Intensive Short-Term Dynamic Psychotherapy (ISTDP) used to address persistent physical symptoms not fully explained by medical condition. They are informed by insights from the interpersonal, neurobiological and affective neurosciences as identified by Malan, (1976) and latterly by psychotherapy researcher Solomon and Psychiatrists Siegel and Neborsky amongst others addressing attachment issues, the brain and body for the relief of physical symptoms (2003).

The encouragement of CBT practitioners by CBT therapist-researchers to return to the therapeutic use of emotion through the theoretical underpinning of the experiential therapists (Woolfolk and Allen, 2007), is useful here in strengthening the bridge towards mutual understanding across therapy modalities. This is beneficial in particular for bridging the gap between STPP and CBT practice interventions relating to emotion linked with PPS. The literature findings of Chapters 3 and 4 also showed

common developments in behavioural interventions for PPS outlined below.

The study entailed a scrutiny of affective 'ACBT' pre-planned process for therapy sessions in Woolfolk and Allen's 10-session (or more) treatment manual (op. cit., 2007). This scrutiny, shows over and above the central function of the facilitation and understanding of emotion linked to the genesis of the PPS, that there are adaptations in common with STPP in relation to PPS interventions that mirror my own practice.

Similar to that identified within the ACBT protocol, the intervention of study depending on clinical need uses:

- Diaphragmatic-breathing for stress management (Wells-Gregorio and Porensky, ccme.osu.edu, accessed Oct, 2015)
- Progressive Muscle Relaxation exercises (McCallie et al., 2006)
- Non-judgemental symptom self-monitoring
- Cognitive appreciation of the emotion linked to PPS

These augmentations are also found in the STPP approaches of primary studies of Chapter 4. These behavioural tasks may be employed as indicated by the responses of the individual in the moment of therapy. The development of a cognitive appreciation of the emotion during STPP intervention, although there may be substantial differences in how this is facilitated compared with CBT protocols, serve the same ends in relation to the impact on the persistent physical symptom in reducing its severity.

The therapy intervention examined in this study is in part underpinned by the theoretical perspectives of the ideals of engagement in therapy of the experiential therapists, itemised in (Table 5.vi). These are enhanced by simple principles of short–term psychodynamic psychotherapy as distilled by Shedler (2010, see Chapter 1 and above) and behavioural therapy adaptations found within the primary STPP intervention for PPS research studies of Chapter 4. All this is set within the use of non-judgemental

mindfulness, self–acceptance and the cognition of emotion (Fruzzetti and Erikson, 2010) and empathic genuineness (Rogers, 1961; 1979). I argue that these elements build a bridge between third generation STPP (Levenson, 2010) and third generation CBT principles (Woolfolk and Allen, 2010) that are applied to interventions for PPS. These concepts are brought together to inform a preliminary analytic framework for the abductive analysis. They are held in common understanding, aligning if not perfectly, then well enough to be readily understood by counsellors and psychotherapists from person-centred, experiential therapy, CBT, third generation CBT and third generation short-term psychodynamic perspectives (Guthrie et al., 2004; Abbass, Campbell et al., 2009).

5.11. The preliminary analytic framework and protocol

To summarise the section above, the broad elements contained within the terms ‘cognitive’, ‘experiential’, ‘interpersonal’, ‘behavioural’ aspects of ‘engagement’ with particular emphasis on ‘emotional processing’ provide a preliminary theoretical structure for the analysis (Table 5. vii). Also, Therapeutic Alliance still remains an important common factor across all psychological therapies and is brought into the preliminary organising themes.

Table 5. vii) The initial devised preliminary theoretical analytic framework

Preliminary Themes	Definition of terms
THERAPEUTIC ALLIANCE	Generating hope. Empathic response. Joint enterprise
DEVELOPING A FOCUS/GOALS FOR THERAPY	Generating goals Nature of those goals
USE OF SYMBOL AND METAPHOR	Use of evocative language, symbol and metaphor to capture the significance of previous experiences
SENSITIVE ATTUNEMENT	Making only tentative interpretations, creating the opportunity for the individual to disagree
FACILITATING EXPRESSION OF EMOTION	Conditions leading to the expression of strong emotion
DEVELOPING COGNITION IN RELATION TO EMOTION AND THE PERSISTENT PHYSICAL SYMPTOM (PPS)	Working within the therapy relationship to understand the emotion in relation to the PPS
BEHAVIOURAL INTERVENTIONS/RESPONSES	New or different actions
OTHER THEMES OBSERVED NOT INCLUDED IN THE THEMES ABOVE	All other qualitative data here, for further coding and analysis

The reflexivity of the T-E in the process of formulating the initial theoretical framework and relating to analytic decisions is integral to achieving an ethical and transparent account.

5.11.1. Preliminary qualitative analysis (Ritchie and Spencer)

The qualitative analysis of the study followed Ritchie and Spencer's Framework Analysis (1994) to facilitate an initial open-coding exercise. This shall give validity to the therapy and some development of the initial preliminary theoretically-based framework shown at Table 5.vi). The core content of the pre-conceived theoretically derived themes (Table 5.vii) shall be all populated by the transcript material, but sub-codes (daughter nodes) shall give specific detail to the content of the themes of engagement. Also, space will be allowed to make provisions for any emerging new themes.

5.11.2. Qualitative Analytic Protocol

The enhanced preliminary analytic framework of themes was developed from the initial 7, to 10 themes (see Table 7.iv). These were entered into the NVivo-10, which is a qualitative analytic data capture programme, with space for un-preconceived findings.

Stage 1. After the anonymised data transcription, it was decided to undertake a familiarisation with the transcribed data. Reflexive notes were recorded on each case to observe for engagement and any unexpected patterns or features and matched against the preliminary analytic framework. Then, the open-coding was checked against a sample of transcripts to explore themes of engagement. These were then matched against the themes of the preliminary analytic framework. With the use of open coding process, the basic structure of the framework, in this case, was enhanced but not substantially changed. Then, the selections of raw data by initial open coding and alignment to the preliminary analytic framework were checked and validated by two senior healthcare researchers.

Stage 2. After brief training, the enhanced framework of 10 themes was input as 'nodes' into the NVivo software package, which is licensed by the

university. The transcripts of therapy were uploaded to 'sources' and each participant was classified as a node. Each therapy transcript was put into a source folder with all 1st sessions, all 2nd sessions etc. segregated and filed in separate folders. Sections of transcribed data, phrases, sentences or brief conversation were allocated within the preliminary analytic codes, session by therapy session from all four cases of therapy. Analytic memos were kept on decisions.

Stage 3. The populated themes were examined within NVivo. After exploration, data was further analysed for common content and difference and verbatim samples were extracted and placed into formulated sub-nodes for each theme if indicated. All content was intended to fit into the main themes and sub-nodes. If not, it was again a principle to add a new thematic code.

Stage 4. Higher extraction of themes of engagement were formulated by looking across all the sub-codes of a theme and observing common processes of engagement over time. Within each theme, the higher themes of engagement for each theme were placed in grids for the display of higher content. These are illustrated by verbatim extracts (7.5.1) and Appendix 15. This material underwent further abstraction facilitated by the reflexive process to question the analysis and to make decisions transparent.

Stage 5. The reflexive accounts of each case are given 'in vitro' to show how the reflexivity suggested by Freshwater and Rolfe (2001) as Type I and Type III Reflexivity, guides the patient and therapist through core elements of the psychotherapeutic work in hand (8.3). Thus, revealing further details of engagement within the therapy process.

Stage 6. Final stages of abduction summate the qualitative data and reflexive observations in and on process (Chapter 8). Cross-case comparisons across types of data allowed further findings to emerge.

5.12. Expected outcomes

The following points summarise the expected outcomes of the Realist Service Evaluation.

- A cross-modality guiding framework underpinning therapeutic engagement with persistent physical symptoms within counselling and psychotherapy practice

The secondary outcomes of Practice-Based Evidence (PBE) provides:

- Evidence of an accountable service
- Evidence for further service development through the exploration of context and mechanisms of change in relation to PPS
- Evidence of somatic symptom severity and mental wellbeing in the service population and any relationship between the two
- A critique of current service measures

5.12.1. Potential impact of outcomes

- Developed theory to underpin skills training in IAPT UK services or equivalent, for addressing PPS
- Raising professional and public awareness of the PPS phenomenon and what helps to reduce its impact
- Potential utility of a guiding framework for enhanced service delivery in primary healthcare for GPs and nurses, generic counsellors, psychotherapists, psychologists and CBT practitioners for individuals with non-ruminating PPS within routine caseloads
- Support of psychosexual therapists undertaking interventions for persistent sexual symptoms
- Raised awareness for policy makers and healthcare commissioners of effective service delivery for non-Somatic Symptom Disorder PPS

5.13. Summary

The Methods Chapter, in meeting evaluation Aim 3 second objective (1.1.) Part I and II provides a comprehensive and transparent account of the various devised evaluation methods. Also, the ethical debate and the use of the reflexive function informs the evaluation methods with the aim of minimising serious harm to participants by protecting their privacy.

Moreover, the development of therapy outcome measures for counselling and psychotherapy is shown as complex (Roth, 2010), even more so for psychosexual therapy (Twigg & Mellor-Clark, 2013). The National Sexology Outcome Evaluation Group (NSOG), that was set up in 2014, continues the task of finding a simple but effective outcome measure tool that can be applied to all interventions for sexual dysfunction and is as yet unvalidated. The validated measures used in this realist evaluation (Table 5.v) will be presented in Chapter 6 and discussed for utility after the final analysis. The value of including personal goal attainment has been expressed in recommendations following the recent further attempt to develop effective outcome tools for psychosexual therapy (Twigg and Mellor-Clark, 2013) and by other talking therapies service evaluators (Lucock et al., 2003).

Common features across Short-term Psychodynamic and Cognitive-Behavioural interventions were found in adaptations for the patient with PPS. Both modalities in their 'third-generation', naturally embrace non-judgemental mindfulness and keep individual choice central to the enterprise, showed to lay emphasis on emotional processing and patient-focused behavioural interventions (4.5.-4.6.). These findings of similarity between the two, gave rise to the transparent development of the cross-modality preliminary theoretical analytic framework of this chapter. Additionally, an analytic protocol, Stages 1-6, was devised to embrace structured reflexivity, thus facilitating the insider position of the T-E to bridge the research-practice gap. Part I Service Evaluation in context and

Part II Process analysis are brought together for case and outcome comparison in Chapters 8 and further discussion in Chapter 9.

Chapter 6: Contextualisation of Intervention and Outcomes

6.1. Aims and objectives of the quantitative analysis

The purpose of this chapter is to facilitate Aim 3, Objective 3 of the evaluation (1.1.) to provide an overview of the nature of the Psychosexual Counselling Service (PSCS) patient population in the context of service delivery at both service level (with data available) and the Therapist-Evaluator (T-E) caseload level and briefly by within-service caseload comparison over a period of twelve months, 2014-2015. Comparisons with other NHS services delivering psychotherapeutic interventions to improve physical and mental wellbeing are provided where possible. The scrutiny of difference between modes of intervention and outcomes at the level of therapeutic orientation was not found quantitatively reliable due to small numbers, the latter analysis is of interest but was therefore not the main focus of this chapter. The broad approach to contextualisation of intervention and outcomes offers increased future transferability of the qualitative findings to similar service settings.

The service setting and context are outlined with a description of the service referral and patient experience pathway. These are followed by the socio-demographics of service users, showing age, gender and ethnicity (N=181). Their primary reasons for referral and the length of symptom history are given to illustrate the persistent nature of the sexual symptoms. Of those in therapy within the service with data available in the period of study, baseline prevalence of somatic symptoms (N=181) and mental wellbeing (N=178) are displayed and their relationship examined at T-E caseload baseline (N=79). This relationship is further explored through outcome data within the T-E caseload of those who began and ended a full therapy contract within the period of study (N=33). These somatic

symptom and wellbeing changes are compared to an alternative within-service caseload (N=9). The two main caseloads within the service are a) the T-E caseload using, in the main, briefly applied psychodynamic principles (Shedler, 2010) and b) the caseload using, in the main, behavioural principles both designed to achieve change in persistent sexual dysfunction (Table 6. vi). Those cases within the study cohort found as 'reliably deteriorated' are examined for their characteristics and personal outcomes (Table 6.vii). The reporting of patient experience of therapy by routine service-wide survey respondents (N=90) over the same time period presents another perspective on outcome (Tables 6.viii) and vix) with breakdown of responses by therapy intervention.

6.2. The service setting

The NHS Psychosexual Counselling Service (PSCS) based in Bedfordshire, UK is currently commissioned by the County's three distinct Borough Councils: Bedford, Central Bedfordshire and Luton. Bedford Borough, inclusive of outlying villages and Luton Borough represent urban county towns. Both towns are cited as having higher than average deprivation levels with ethnically diverse populations. The third borough, Central Bedfordshire, is the largest Unitary Council in England by geographical area, but the least densely populated with lower ethnic diversity and fewer indications of deprivation (ONS, 2011) (Table 6.i).

Table 6.i) General population demographics

	Percentage of population (ONS, 2011)			(Communities & Local Govt., 2015)	
Borough Council & Population	Asian	Black African/ Caribbean	Other White	Index of Multiple Deprivation (IMD) rank	Lower super output areas (LSOA) within 10%* within 10-20%**
Bedford Borough 157,479	11.4[1]	3.9[2]	9.1[3]	Mid-range	5*
Luton Borough 203,201	30[4]	10[5]	7	Higher range	9*
Central Bedfordshire 254,381	1.3[6]	1.4	2.8	Lower range	5**

[1]Indian 5.2%, Pakistani 2.1%, Bangladeshi 2%; [2]African 1.7%, Caribbean 1.8%; [3]Italian & Polish;
[4]Indian 5.2%, Pakistani 14.4%, Bangladeshi 6.7%; [5]African 4.5%, Caribbean 4%.
[6] Indian 1%.

The PSCS (see Chapter 1.3 for more detail) sits within the local NHS Contraceptive and Sexual Health Service, Cambridgeshire Community Services (CCS). It is currently staffed by 1.6 whole time equivalent therapists registered with the professional accrediting bodies the British Association for Counselling and Psychotherapy (BACP) or the College of Sexual and Relationship Therapists (COSRT), with administrative support. The therapists have each worked in the field for a minimum of ten years and are aged between 50-57years and of mixed gender and sexuality. The two major therapy caseloads use different emphases. The caseload of study prioritises engaging core psychodynamic perspectives and the comparison caseload prioritises behavioural interventions for persistent sexual symptoms.

The Service pathway outlined in Fig. 6.1 shows the patient journey. Individuals or couples are referred to the PSCS to address persistent sexual dysfunction, concerns regarding sexuality and gender and historical sexual abuse or sexual assault. Referrals are accepted from any healthcare professional identifying the issue with the patient, such as the primary care physician (GP), specialist secondary care hospital consultant including mental health specialists, nurse specialists and physiotherapists from primary and secondary care settings, drug and alcohol services,

independent sexual violence advisors, social care professionals and the voluntary sector (such as Women's Aid). To aid access to vulnerable groups, self-referral may be agreed. Individuals or couples are generally accepted into the service by the Clinical Lead or deputy. The service user requires the capacity and willingness to reflect, with support, on their reason for referral. The aim is to find a patient-centred pathway to resolution or acceptance of their condition and personal circumstances.

An initial risk assessment is undertaken based on the information supplied by the referrer. The referrer may be contacted for further information before an acceptance into the service and to ensure that where necessary, a physical screening has been undertaken by their GP. This is to identify and treat organic causes prior to or concurrent with referral. As the PSCS serves an ethnically diverse population all patients are asked on their Service 'Opt–in Form' whether they would like to have an interpreter present to assist communication or for any other access needs. As is deemed good practice, the PSCS does not use relatives or friends for translation. The interpreting service engaged by the NHS Trust is pre-booked on request and supplies trained interpreters from beyond the county boundaries during all sessions requested by the individual. This is found acceptable, reducing fear of recognition within the local community.

After actively 'opting-in' to the Service, individuals or couples are allocated to the first available therapist for assessment and given the choice to continue with that therapist or transfer to an alternative. Patients are offered a contract of a further six, 50 minute appointments at 3-4 week intervals. This represents a first contract of therapy. Personal goals for therapy are developed and worked on in partnership. At therapy end individuals and couples are offered an open-door access to the clinic over the following six months for a self-generated appointment to review any further needs. The patient feedback on this provision in previous years showed that individuals and couples feel more confident to end their therapy knowing they can return to the service in the future if needed. By

service audit 2013-2014, only a small minority (under 7%) choose to make a review appointment.

For certain cases, such as non-consummation and sexual, physical or emotional abuse histories or for those with more intractable persistent symptoms, the therapy can seamlessly move into a second contract and occasionally a third if it is agreed as clinically indicated. Again, in the realities of practice, this represents a small minority of 5-10 cases per year. The service pathway is found at Figure 6.1.

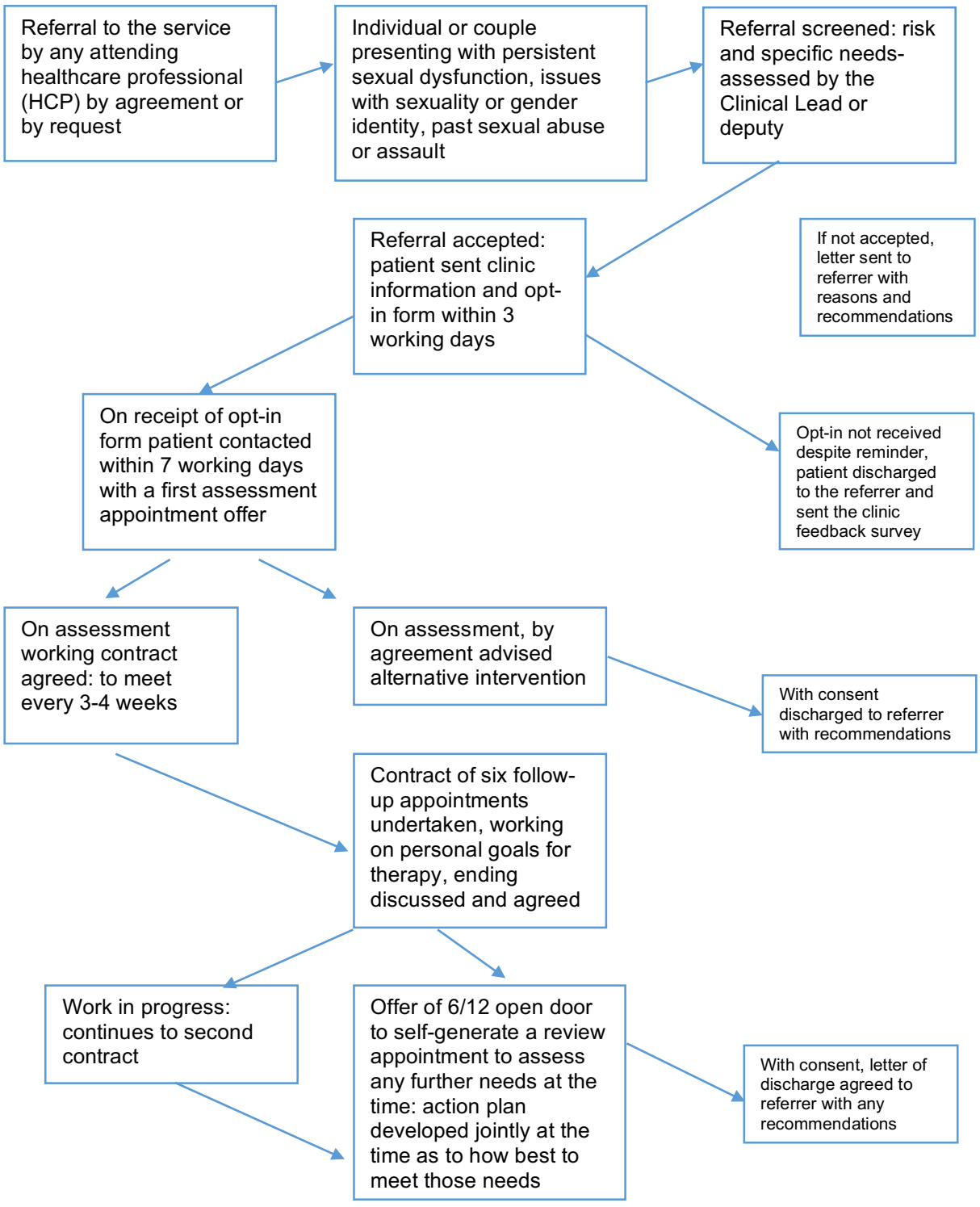


Fig. 6.1 Referral and patient experience pathway

Data extracted from the Psychosexual Counselling Service (PSCS) during the evaluation period of study from 1st April 2014 to 31st March 2015, highlighted that there were a total of 298 referrals to the service, of whom 20% (n=60) did not choose to 'opt-in'. It was not possible, within the constraints of this evaluation to fully define why those individuals did not choose to continue with their referral. Of those referred, just three were inappropriate, being outside the service parameters. These were received from Mental Health and Learning Disability Services and concerns regarding suitability were discussed with the referrers. From the data available, patients were most often referred by their GP and community Mental Health professionals (74.5%), with specialist secondary care medical and surgical teams accounting for a quarter (25.5%) of all referrals.

The features of the service population are reported in the following section with benchmark comparisons made where possible with other services in non-acute healthcare settings. Comparison data with other psychosexual counselling/therapy service populations regarding demographics were hard to obtain in detail, due to the lack of, or inaccessibility of the data. However, it was possible to establish the ratio of male to females entering into therapy (6.3.1) and the four most common reasons for referral from three other English Psychosexual Therapy Clinics (6.4.1).

A comparison with the local Improving Access to Psychological Therapies (IAPT) Wellbeing Services serving the same demographic delivering therapy interventions by self or professional referral within the community, acts as a source of comparison for the transferability of findings at a later date. As services for persistent 'medically unexplained' physical symptoms are in the early stages of development (De Lusignan, Jones et al., 2013), where data is available for comparison, it is given.

6.3. Socio-demographics

The characteristics of patients' (n=181) are of those who were in therapy (1st April 2014 to 31st March 2015) with data available; their gender, age and ethnicity are presented below.

6.3.1 Gender

In the period of study more men entered into therapy (60%, n=109) than compared to women (40%, n=72) which is markedly higher than the national population breakdown by gender (male, 52%; female, 49.8%) (ONS, 2011). Comparison data from the in-house audit report from the Dean Street Sexual Health Clinic, London NHS Psychosexual Therapy (PST) Service, Chelsea and Westminster Hospital NHS Foundation Trust during the time period 2012-2014, found a similar incidence of males entering therapy (60%) (Kunelaki, unpubl.). Other services have shown an even higher rate of male users. For example, local audit data from the Sheffield Health and Social Care Porterbrook PST Service showed there were 67.88% males who entered into therapy in the period 2015-2016. However, the males entering therapy (38%) within the Bristol Sexual Health PST Service in this same period by local audit was more in line with the male population engaging with general wellbeing services (see below). No conclusion as to the reason for these differences can be drawn at this stage.

Local data within psychological services has shown lower uptake by males. For example, the Luton (IAPT) Wellbeing Service, during the period 2015-2016, highlighted a lower response by males (36%) when compared to national statistics (ONS, 2011). This was mirrored by the Bedfordshire (IAPT) Wellbeing Service male users (35%), from the Bedford & Central Bedfordshire 2011 population census showing male (49.4%) to female (50.6%) (ONS, 2011). However, the higher male ratio found within the service of study (PSCS) has also been alluded to within some of the IAPT Pathfinder pilot sites delivering interventions for Long

Term Conditions (LTC) and Medically Unexplained Symptoms (MUS) (De Lusignan, Jones et al., 2013), although no percentage figures are given in the latter report. This phenomenon of a generally higher attendance by men seeking ways to address persistent physical dysfunction warrants further research.

6.3.2 Age

The age of patients ranged from 17-69 with a mean age of 36.6 years (SD=12.28) (Fig. 6.2). The highest percentage of patients referred to the service were aged between 26-45 years (55%, n=99). Lowest referral rates were found in patients aged 66 years and over (4%, n=4). The Luton and Bedfordshire IAPT Wellbeing Services which serve the same populations (2015-2016) demonstrated a broadly similar age distribution within their services, with the highest numbers in the 25-44-year age group and 4-6% aged 65 and over (HSCIC, 2016). The found uptake of services does not necessarily reflect the need for such service interventions across the population. Those over the age of 60, also evidenced within the borough of Bournemouth and Poole IAPT 2009-2010 service report (2010), continue to remain proportionally under-represented within psychological services. Further research in improving access to psychological interventions for older adults is indicated to include services that address persistent sexual symptoms.

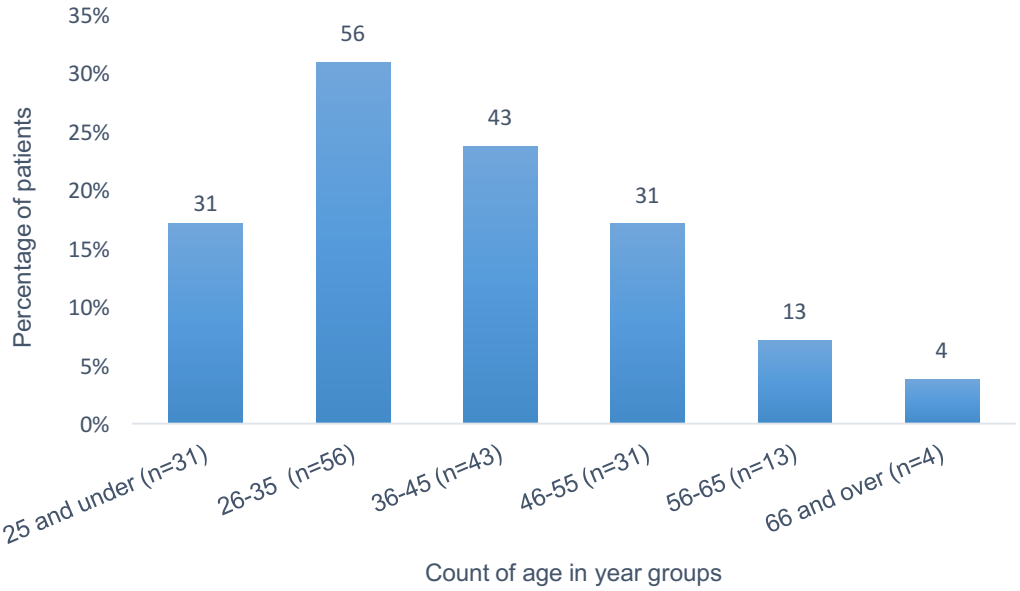


Fig. 6.2 Age profile (2014-2015) of all service users (n=181)

6.3.3 Ethnicity

Figure 6.3 shows that the majority of service users were classified as White British (64%, n=116) followed by Asian (14%, n=25) (Pakistani, Bangladeshi, Indian). The next largest ethnicity was 'Other White' (9%, n=16) which is more than double the 2011 separate Census figures for Bedford, Central Bedfordshire and Luton Borough Councils (ONS, 2011). This included all patients who were European who have recently settled within the County. African/Caribbean individuals (3%) with the inclusion of 'mixed black' (2%) represented the cross-county black population mean (5.1%). The county-wide ethnicity figures studied (Fig. 6.3) do not separate the Luton referrals from the rest of the county referrals to the service and so it is not clear whether the uptake of the service truly reflects the 2011 Black population of Luton (9.8%) (ONS, 2011). Nevertheless, service users are broadly representative of the ethnicity within Bedfordshire (Table 6.i).

The central London NHS Community Psychosexual Clinic findings (Kunelaki, unpubl.) also showed that the highest percentage of patients were White British (40%; n=295) with a high level of referrals from 'any

other White' category (including European, Australasian and South African) (24%; n=175). The remaining 'Black' and Minority Ethnic groups (BME) (33%) which include Asian ethnicities were representative of the ONS (2011) ethnicity figures for London as a multi-cultural capital city.

The local Luton (IAPT) Wellbeing Service had a higher than expected (10.61%) level of black ethnicity referrals for the year 1st April 2015-31st March 2016 (HSCIC, 2016). These comparisons suggest that ethnic minorities are finding psychotherapeutic health and wellbeing services, including Psychosexual Therapy Services, increasingly accessible compared to the earlier findings within IAPT Services (Clark, 2011; De Lusignan, Chan et al., 2013).

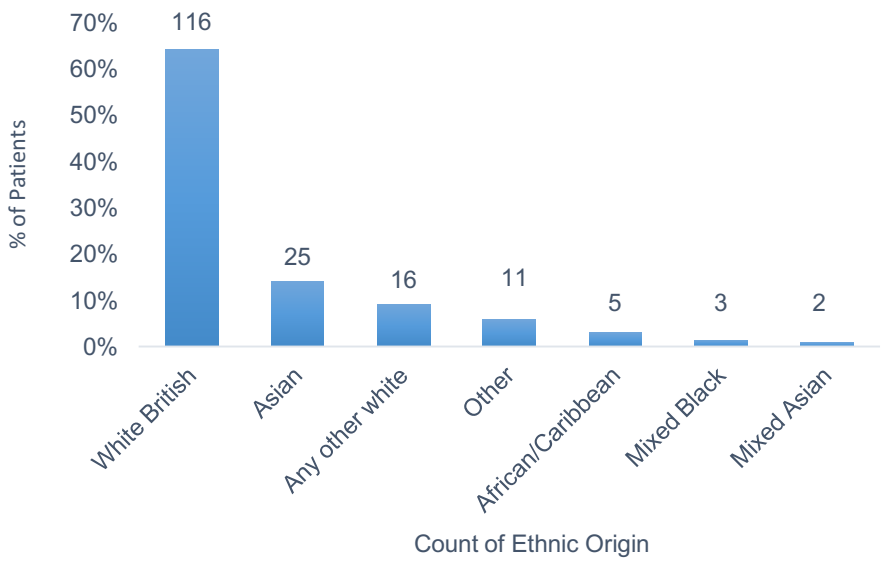


Fig. 6.3 Ethnicity of clinic population(n=181)

6.4. The nature of persistent sexual symptoms

6.4.1. The primary reason for referral

The primary reason for referral to the service in the period 2014-2015 are grouped into eight broad sexual categories: Pain, Desire, Arousal, Child Sexual Abuse (CSA), Gender Dysphoria (GD), Orgasm, Sexuality and Other (see Table. 6.ii). Referral reasons of those who entered into therapy are presented in Figure 6.4 by these broad categories. The four most common reasons for referral were 'Arousal' inclusive of Erectile Dysfunction (ED) 28% (n=51) of the total cohort (n=181), 'Pain' inclusive of Vaginismus, i.e. pain on initial vaginal penetration 23% (n=42), 'Orgasm' which includes Rapid Ejaculation (RE) 16% (n=29) and problems with lack or loss of desire 15% (n=27).

Table 6.ii) Categories for the reason for referral (2014-2015)

Reason of referral	Definition and inclusions
Pain	Vaginismus, dyspareunia, vulvodynia and male genital pain
Desire	Primary: never experienced sexual desire. Secondary: a loss of desire
Arousal	Erectile dysfunction (ED), female lack of lubrication: primary and secondary
Child Sexual Abuse (CSA)	Early sexual exposure, viewing or participating by coercion/manipulation. Infrequently given as the primary reason for referral CSA. If disclosed during the process of therapy it is not recorded as a primary reason for referral
Gender Dysphoria (GD)	Men and women who find their assigned gender deeply unacceptable
Orgasm	Primary or secondary premature ejaculation (PE) otherwise known as rapid ejaculation (RE)(APA, 2013a); delayed ejaculation & anorgasmia
Sexuality	Worry or uncertainty over sexual preference
Other	Sexual addiction: virtual or actual; Paraphilia: use of objects or body parts as essential to obtaining and sustaining sexual arousal causing problems with intimacy

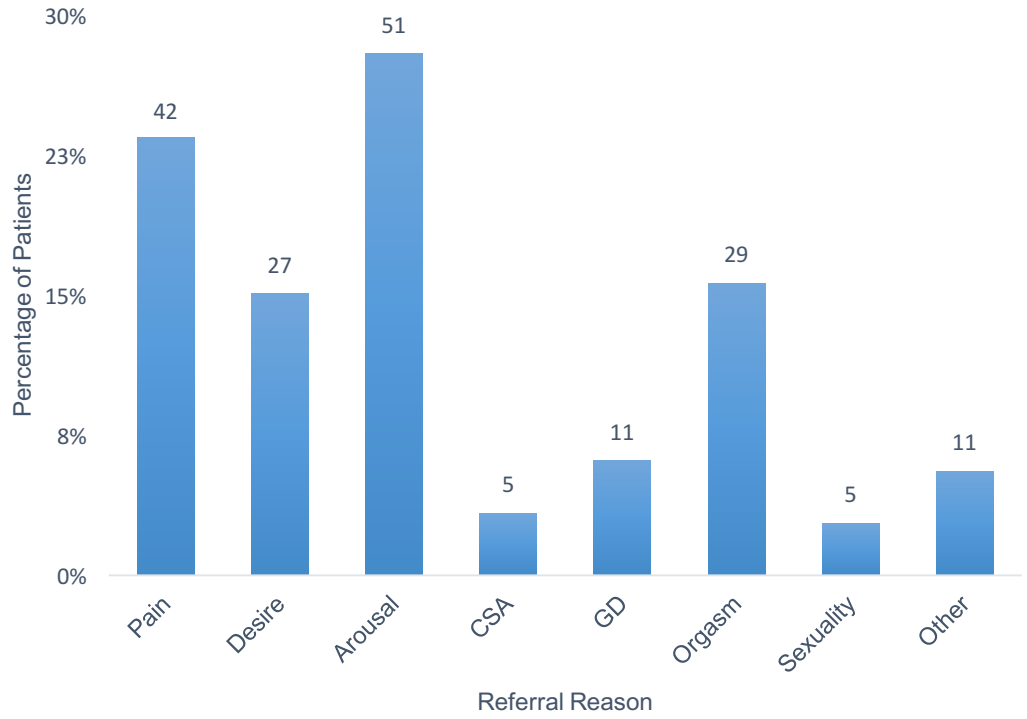


Fig. 6.4 Primary referral reason relating to persistent sexual symptom (n=181)

Comparisons in primary reason for referral are compared by informal in-service audits of three English NHS Psychosexual Therapy (PST) services, Dean Street Clinic, London (Kunelaki, 2012-2014), Bristol PST (Pullen, 2015-2016) and Sheffield Porterbrook Clinic (Hanson, 2015-2016) (Table 6.iii). Some of the difference in the top four reasons for referral within these four PST providers may be due to the referral pathways established locally. The referral demographics in this comparison suggest that there are service adaptations to meet local demand. These reasons for referral show within-service variance from year to year, substantiated by the PST local audit for 2015-2016 (Kunelaki, unpublished). However, much more could be done to ensure equal access for those who may benefit from specialist intervention regarding sexual function and other persistent physical symptoms (PPS) that are found (see section 6.5.1). The opportunity of including attention to other PPS as a value-added intervention within psychotherapy services becomes evident, especially in view of symptom persistence seen at Fig. 6.5.

Table 6.iii) Most common reason for referral

PST 'in-house' service audits (unpublished)	The four most common categories of referral %(n=where available)			
	1st	2nd	3rd	4th
Bedfordshire & Luton 2014-2015	'Arousal' including Erectile dysfunction (ED) 28% (51)	'Pain' including Vaginismus 23% (42)	'Orgasm' including Rapid Ejaculation (RE) 16% (29)	Sexual 'Desire' (Low SD) 15% (27)
Dean Street, London 2012-2014*	ED 31%	RE 10%	Sex Addiction 9%	Low SD 8%
Porterbrook, Sheffield Within 2015-2016*	ED 34%	Pain 14%	Low SD 13.5%	RE 7%
Bristol Within 2015-2016*	Pain No % available	ED No % available	SD No % available	RE No % available

*Provided by personal communication through PST service leads

6.4.2. Length of symptom history

The length of history of the presenting troubling sexual dysfunction (Fig. 6.5) gives context to the referrals, showing the extend in symptom persistence at baseline (N=181). Six percent had more than a 35 year experience of their persistent sexual symptoms, with 9% having a 21-35 year history. A further 17% reported a 11-20 year symptom history and 22% experiencing them over a 6-10 year period. The majority of this cohort (42%) were found in the 1-5 year category with just 3% with a symptom history of under a year. These lengths of history of persistent physical symptoms not getting better over time or helped by routine medical intervention, firmly place such sexual symptoms of 'dysfunction' alongside other PPS of more than six month's duration. This raises the question of why individuals with these persistent symptoms have either not sought help or not found earlier resolution. This may relate to a lack of PPS understanding or effective services to which to refer, indicating the need for qualitative research into patient experience of health service provision in this area.

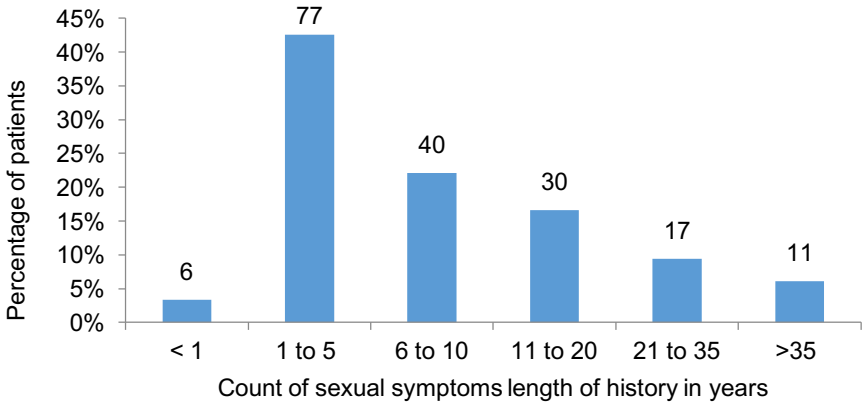


Fig. 6.5 History of persistent sexual symptoms in years (n=181)

6.4.3. Referral acceptability

The non-attendance rate (DNA) can provide an indication of service or initial referral acceptability to service users. The DNA rate of first appointments across the service (n=181) in the twelve-month period 2014-2015 was found to be 8% (n=15). The reduction in first appointment DNA rates may have been facilitated by the requirement to return the Service 'Opt-in Form' to confirm their intention to engage with the service and by a 48-hour mobile telephone SMS text reminder before their first appointment. Unfortunately, the DNA rate for first appointment was not readily accessible from the comparison PST services and so could not be included.

However, a primary care mental health service studied by Gilbert et al., (2005) of some equivalency in delivery, gives benchmarked outcomes. The assessment appointment DNA rates which are used for comparison were derived from the 2132 total referrals that were received over a 34 month period. Of these, 26% percent did not attend (DNA) their booked assessment session. The characteristics of those who were most likely to DNA assessment in Gilbert's study were not identified.

6.5. Somatic symptom and mental wellbeing profile

6.5.1. Prevalence of Somatic Symptoms at baseline

The observation in practice of other persistent physical symptoms discovered during the therapy process came into the former DSM-IV-TR category of 'Undifferentiated Somatoform Disorder' (APA, 2000). This prompted the investigation into the wider incidence of persistent physical symptoms (PPS) over and above the persistent sexual dysfunction within the clinic population. As a consequence, in 2013 the Somatic Symptom Severity Patient Health Questionnaire-15 (PHQ-15) (Korber et al., 2011) was introduced as a routine clinic measure. This local decision mirrored the suggestion by Burton: to check and act on the evidence of persistent somatic symptoms in GP consultations by using the PHQ-15 in General Medical Practice (Burton, 2013).

The selected Patient Health Questionnaire measure, the PHQ-15 for somatic symptom severity, is not in itself, as stated at 5.6.1.ii., a diagnostic tool, but acts as an indicator of potential somatisation (Korber et al., 2011). Clinical cut offs on the PHQ-15 scoring are: 0-4 points indicating 'no somatisation'; the 5-9 point cut off, 'mild somatisation', the 10-14 point cut off, 'moderate somatisation'; 15 points or more indicating 'severe somatisation' (min 0-max 30). The scoring takes place by choice of three set comments against a 15-point symptom list (see Appendix. 5 & 5.6.2) as 'not bothered at all gives a zero score, 'bothered a little' gives a score of one point and 'bothered a lot', a score of two points.

At baseline, before coming into the first therapy session, 70% of the clinic population showed self-reported persistent physical symptoms over and above their persistent sexual symptom presentation (Fig. 6.6). Of these patient scores of somatisation, 58% (n=105) were 'mild to moderate' with 12% (n=22) as severe. This evidence reflects previously informal practice-based observations within the Psychosexual Counselling Service confirming the value of Burton's suggestion that the somatisation or PPS

phenomenon is worth noting and acting on in routine non-acute clinical caseloads.

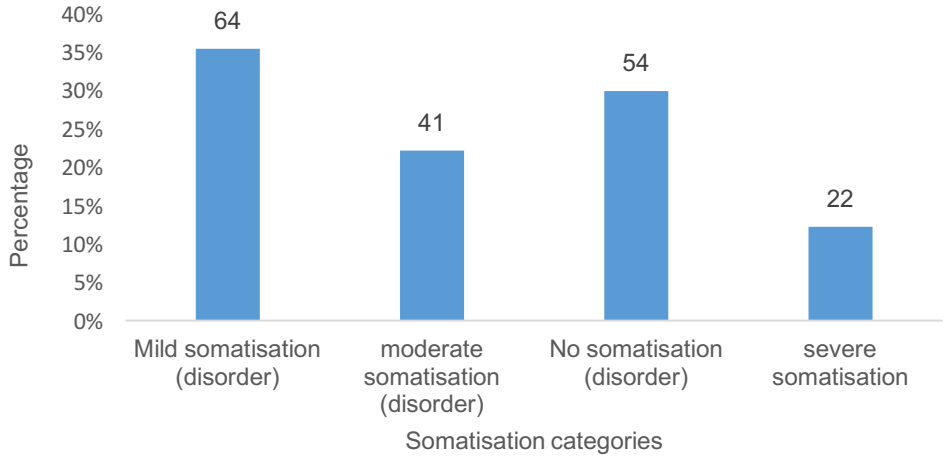


Fig. 6.6 Persistent symptom severity profile of PSCS population at baseline (n=181)

6.5.2. Mental Well-Being at baseline

Persistent 'medically unexplained' physical symptoms are frequently reported as most commonly linked to anxiety and depression (Burton, 2013: Creed et al., 2011) and for this reason are deserving of specialist intervention. However, through the realist broad scoping of the literature (Chapter 3) 51% of those with PPS were found *not* necessarily comorbid with anxiety and depression (Sattel et al., 2012; Steinbrecher et al., 2011; Fink et al., 2007; Nimnuan, 2001). As an illustration suggesting the need for care reagarding the assumption that treating concurrent depression will resolve PPS, De Veaugh-Geiss, (2008) found no difference in persistent pain improvement in patients who achieved partial or full remission in depression. Equally, interventions resulting in highly significant PPS reduction are not necessarily found to impact on depression scores (Rohricht et al., 2013; Sattel et al., 2012). A careful examination of mental wellbeing is therefore required for this study of PPS in non-acute healthcare.

The Warwick and Edinburgh Mental Well-Being Scale (WEMWBS) is discussed at 5.6.3. as a positive mental health wellbeing measure (see Appendix 5). The WEMWBS showed across a general Scottish population (n=1749) a median wellbeing score of 51 (Stewart-Brown et al., 2009) with cross cultural evaluation equivalence (Taggart, Friede, Weich et al., 2013).

A review of UK intervention studies to improve mental and physical wellbeing was undertaken to examine the findings of the WEMWB scale (Maheswaran et al., 2012). Wellbeing (WEMWBS, 14-70), varied at baseline from scores of 34 to 51.6. The whole population of this PSCS evaluation, within the dates of study, for whom there were baseline wellbeing scores (N=178) showed the majority (74%) to be within the wellbeing parameters (34-51.6) as found by Maheswaran et al., (2012).

The PSCS clinic population with scores available (n=178) reveals a baseline mean using the Warwick and Edinburgh Mental Well-Being Scale (WEMWBS) of 44.11. It is noteworthy however, that in the PSCS population, 11.23% (n=20) showed a baseline wellbeing of $\leq$29 and that, 14% (n=25) showed exceptionally high wellbeing scores of $\geq$56, suggesting a bell curve population distribution seen at Fig. 6.7. Gremigni & Bianco (2011/12) developed the following cut off points for the WEMWBS measure concerning non-clinical, at risk and possible depression. Clinical cut-offs are suggested as WEMWB score of >44.5 as non-clinical, <44.5 as 'at risk' of depression and <40.5 as 'possibly' depressed. The mean score of population wellbeing at baseline of 44.1 falls into the cut-off score indicative of being 'at risk' of possible depression of <44.5, i.e. of lowered mood. Of the PSCS population (n=178) examined for the study in relation to depression, Fig. 6.7 shows that 52.24% (n=93) were in the 'non-clinical' group with 48.31% (n=86) at 'possible risk' of depression or 'possibly' depressed. The breakdown of wellbeing scores is therefore further explored in relationship to somatic symptom severity for caseload baseline measures (n=79) (Table 6.iv).

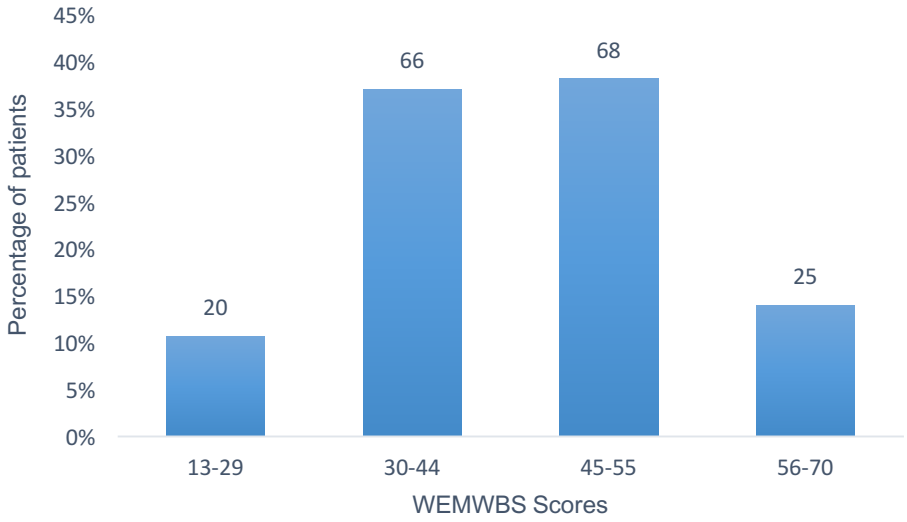


Fig. 6.7 Wellbeing score of PSCS population at baseline (n=178)

6.5.3. Relationship between mental wellbeing and somatic symptom severity

The question of relationship between mental health and somatic symptom severity arose from the literature introduced in Chapter 1 and was detailed further in Chapters 3 and 4. The development of IAPT interventions for persistent physical symptoms, still in the early stages, suggested that as depression and anxiety were treated by CBT, somatic symptoms would improve due to their co-morbidity. A number of authors of primary research and systematic literature reviews have concluded with the suggestion that mental health co-morbidity is a primal consideration for treatment in relation to PPS (Burton, 2013).

The examination of this relationship pattern within the service evaluation is shown again as one of importance for underpinning psychotherapeutic interventions for PPS. The baseline measures of mental well-being and somatic symptoms are outlined in relationship to depression at T-E caseload level, data available (n=79) (Table 6.iv). The caseload data (n=79) shows findings of interest between wellbeing and mild to severe

somatic symptom severity (PPS): in the 'non-clinical' group (n=42), 64.28%, in the 'at risk of depression' group (n=9), all had other somatic symptoms and of the 'possibly depressed' group (n=28), 89.28% had other mild to severe somatic symptoms. However, on further examination, in the non-clinical group only 14.28% show moderate to severe somatic symptoms but in the 'at risk of depression' group, 55.55% and in the 'possibly depressed' group 60.7% (Table 6.iv). This suggests a trend, that those with poorer wellbeing measures are more likely to experience moderate to severe persistent somatic symptoms. In view of this, a further examination of the relationship between mental wellbeing and somatic symptom severity was undertaken with the data to hand.

Table 6.iv) Caseload baseline mental wellbeing scores (WEMWBS) and their relationship to somatic symptom severity (PHQ-15)

WEMWBS scores in relation to non-clinical, at risk or possible depression	% in depression categories (n=79)	PHQ-15 cut off scores for symptom severity	% in somatic symptom severity category by depression cut-off bands
Non-clinical >44.5	53.16 (42)	None <5	35.7
		Mild 5-9	50
		Moderate 10-15	9.52
		Severe >15	4.76
At risk <44.5	11.39 (9)	None<5	0
		Mild 5-9	44.44
		Moderate 10-15	33.33
		Severe >15	22.22
Possibly depressed <40.5	35.44 (28)	None<5	10.7
		Mild 5-9	25
		Moderate 10-15	39.28
		Severe >15	21.42

A Pearson's Correlation using SPSS v21 showed a significant moderate inverse relationship ($r(82) = -.501$, $p<.001$) between mood and somatic symptom severity within the caseload at baseline suggesting that the lower the mood, the higher the symptom severity. Those individuals with PPS are confirmed as not necessarily having a depression comorbidity but are more likely to have lowered mood. This evidence however, cannot

confirm causation either way. Change over time in therapy is further explored.

6.5.4. Change over time in therapy

The PHQ-15 and WEMWBS measures were further compared over Time 1, 2 and 3 within the caseload of study for those who completed a full contract of therapy (n=33) (Table 6.v).

The following study identifies minimal benchmarking for the change in scores over time. The study of change in psychometric profiles during medical treatment for lower urinary tract infection, examines the use of PHQ-15 (Cho et al., 2015). In the study by Cho et al., (2015) a changed PHQ-15 mean score from baseline to end of treatment showed a point 0.60 change from baseline mean scores 4.90 (SD 4.21) to 4.30 (4.05) as a statistically significant 'improved' change (p=.019). However, such a small change in score was not found to reflect clinical improvement in symptoms and therefore could not be carried over for this study. However, De Veaugh-Geiss (2008) examined somatic pain and its relation to depression and started with important change at ≥ 3point change on the PHQ-15 scores. A final regression model was used by De Veaugh-Geiss with pain improvement defined as ≥ 2 points (PHQ-15) of score change.

From the Maheswaran et al., (2012) study of mental and physical wellbeing interventions using the WEMWB scale the standard error of mean (SEM) was comparable such that a single increased score in the WEMWBS could be enough evidence of enhanced wellbeing by the end of the intervention. However, the authors add that a change score of 3 or more, equivalent to 1 SEM (2.4-2.8), greater than the measurement error in the studies examined, could be safely interpreted as important.

In order to measure somatic symptoms and wellbeing over time in therapy, the time points (T) were taken from baseline of those within the caseload of study who began and completed a full therapy contract within period (n=33), i.e. T1 immediately before the start of therapy, T2 as mid-way and

T3 taken at the start of the last session of therapy (Table 6.v). Repeated measures ANOVA analysis confirmed somatic symptoms severity (PHQ-15) significantly decreased at the .05 significance level from T2 (M= 8.81; SD= 6.62) to T3 (M= 7.45; SD= 6.85), Mean Difference (MD) -1.364, (95% CI [.316, 2.41], SE .415. *p*= .007). Further, there was a significant increase of wellbeing scores (WEMWBS) at the .05 significance level from T2 (M=44.19; SD=11.41) to T3 (47.25; 13.56), MD 3.063, (95% CI [.148, 5.97], SE 1.15, *p*=.037). No other significant differences were found. These baseline and end of intervention outcomes indicate here that an engagement in a full course of therapy using brief psychodynamic principles over time achieves significant change both in general somatic symptom reduction and improved mental wellbeing.

Table 6.v) Somatic and Wellbeing scores over time in therapy

Measures	**Somatic Symptoms (PHQ-15) (n=33)**
Time	Mean (SD)
T1	8.48 (6.03)
T2	8.81 (6.62)
T3	7.45 (6.85)
	Wellbeing scores (WEMWBS) (n=33)
T1	44.12 (11.26)
T2	44.19 (11.41)
T3	47.25 (13.56)

The results of cross-caseload comparison of outcomes (Table 6.iv) using different therapy modalities show a contrast in outcomes and are further explored by standards equating to the concept of 'reliable improvement' (HSCIC, 2015, Appendix 2). If positive or negative change is found from baseline to the last measure beyond the measurement error of the particular tool, this is accepted as a measure of 'reliable improvement' or 'reliable deterioration'. This can provide a means of comparing service outcomes for improving mental wellbeing and physical health.

The T-E intervention caseload, using briefly applied psychodynamic principles, showed those who completed a first contract of therapy (n=33) within study dates reach reliable improvement in wellbeing at 39.39%

(n=13) and in reliable improvement in somatic symptoms, 36.36% (n=12). In the caseload using behavioural principles, examined here for comparison, 33.33% (n=3) were found with reliable improvement in wellbeing and 55.55% (n=5) in somatic symptoms (Table 6.vi). It appears here, that the behavioural intervention results in a substantially greater improvement in somatic symptoms than wellbeing compared to the study caseload which offers the opposite finding. However, the 19% difference between the somatic symptom change found in Table 6.vi) is represented just by two individuals and must therefore be interpreted with caution.

Returning to the PSCS caseload comparison, there are substantial differences found in the numbers engaging until the end of the therapy contract of assessment plus six follow-up sessions once a month. The total numbers discharged within the evaluated PSCS therapy caseload (n=79) during the period of study were (n=62) and of these, (n=33) completed a full therapy contract. This represents, of the total discharged within period, a 53.22% rate of engagement. Within the comparison caseload (n=96), using in the main behavioural principles, of discharged patients within date (n=45), the rate of engagement to the end of a full course of therapy was 20% (n=9). This finding aligns with higher drop-out rates for studies of cognitive-behavioural interventions in comparison to higher retention rates within short term psychodynamic therapy intervention studies (Abbass, Kisely et al., 2009). Nevertheless, when individuals *did* engage to the end of therapy, although numbers are small, important change in wellbeing and improved somatic symptoms were found across the caseloads (Table 6.vi).

Table 6.vi) Caseload outcome measures comparison using benchmarked outcomes

Caseload discharges 2014-2015 N= (n=completed therapy contract)	**Indicators of change by percentage of those who completed a first full therapy contract**					
Biref psychodynamic intervention N=62 (n=33)	Important Change ≥3^	No change	Worse	Improved ≥2*	No change	Worse
	WEMWBS % (n=33)			PHQ-15 % (n=33)		
	39.39	39.39	15.15 (5)	36.36	45.45	18.18 (6)
Comparison behavioural intervention N=45 (n=9)	WEMWBS % (n=9)			PHQ-15 % (n=9)		
	33.33	33.33	33.33 (3)	55.55	33.33	11.11 (1)

NB: ^'important change' (Maheswaran et al., 2012); *'improved' (De Veaugh-Geiss, 2008)

In comparison with the engagement rates found within-service, the annual report on the use of IAPT services in England, 2014-2015 (HSCIC, 2015) with the predominance of CBT interventions, defines a course of treatment as engaging with a minimum of two treatment appointments. On this basis the IAPT report showed that of those referred and accepted into the IAPT services, in this period, for the treatment of anxiety and depression (n=815,665), that 41.8% (n=468,881) finished a course of treatment (i.e. after a minimum of two treatment appointments). This is an illustration of the care needed in comparing therapy modality interventions for effectiveness.

Furthermore, the IAPT Pathfinder Project for heterogenous interventions for mixed Long Term Conditions and PPS report improvement as including 'either favourable or no change' (De Lusignan, Jones et al. 2013, p.30). The percentage outcomes include scores of zero-change in the positive outcomes presented. Of the three scales found with utility in the pilot Pathfinder Project, the zero change scores included in positive outcome represent between 21.13% in the Work and Social Adjustment Scale, 21.96% of the PHQ-9 score for depression and 22.67% of the Generalised Anxiety Disorder measure (GAD-7). This gives a different interpretation of

positive outcome without the IAPT standards of 'reliable change' (HSCIC, 2015, Appendix 2).

It is of interest that across the compared within-service caseloads, an overall nine cases were found to have 'reliably' worse scores at the end of therapy (see 6.5.5. for discussion). Six of these were found within the T-E caseload and three within the contrasting caseload. In the following section the individual case contexts shall be examined for any common findings or difference.

6.5.5. Examination of cases with 'reliably deteriorated' scores

Realist evaluation seeks to undertake what works for whom, how, and in what circumstances and looks for exceptions (Pawson, 2013). There were nine cases across the compared caseloads with reliable deterioration scores showing at least one worsened score beyond the measurement error for the tool and the other score deteriorated or within the 'no change' parameters (HSCIC, 2015, Appendix 2). These cases are examined for commonalities and difference (Table 6.vii).

Of those who show 'reliable deterioration' across both caseloads (N=9), a higher proportion (n=7) were female. The ages ranged from under 25 (n=1), from 26-35 (n=4), between 36-45 (n=2), and between the ages of 46-55 (n=2). A higher representation was shown in the 26-35 year age group and of women. The ethnicity of those (N=9) with reliably deteriorated scores were White (n=6), Other White (n=1), Pakistani (n=1) and Black (n=1).

Outcome comments revealed that despite 'reliable deterioration', personal goals for therapy (n=3) were nevertheless largely achieved, one from the behavioural intervention. Of those with reliable deterioration in wellbeing and somatic symptoms and reporting minimal change in reaching personal goals for therapy (n=2), one was referred onwards from the behavioural intervention for couples' therapy to work on general communication and

the other referred on for weekly psychotherapy. Of those who expressed a continuing need for support to achieve their personal goals (n=3), one was referred on from the behavioural intervention to a specialist Gender Identity Clinic and the remaining two continued to a second contract of therapy within the T-E caseload. The individual (n=1) with life-long depression within the T-E intervention was able to recognise and value personal achievements and planned to continue to work towards her goals following discharge. All were offered an open door for a self-generated review appointment if needed.

The closer examination of these cases (Table 6.vii) suggested that severe childhood trauma characterised the female individuals with reliably deteriorated scores and that extended teenage or adult adversity are shown here within the male case histories. A tentative conclusion therefore might be drawn as to why these cases showed 'reliable deterioration' on the validated wellbeing and somatic scales. Nevertheless, it is of profound importance to note that all of these individuals (N=9) verbally reported to their therapist at the end of therapy that engaging with the therapy had been a valuable life-journey experience and that a third of this group, despite 'reliable deterioration', had reached their personal goals for therapy within a first contract of therapy.

Table 6.vii) Characteristics of cases with at least one deteriorated outcome measure

Case	M or F	Age	Ethnic Group	Primary symptom	Length of primary symptom in years	History	WB score T1-T3 (≥ -3)	PHQ score T1-T3 ($\geq +2$)	No. of times seen	Therapist concurrent outcome comment
1	F	48	W	Child Sexual Abuse (CSA)	37	Childhood adversity, Adult DV/SA	58-44 (-14)	5-3 (-2)	12	Goals largely achieved
2	F	44	W	Loss of desire	3	Childhood adversity 3 auto-immune diseases	53-32 (-21)	6-7 (+1)	7	Working towards goals. Agreed 2nd contract
3	F	40	OW	Loss of desire	16	CSA, DV, life long depression	42-36 (-6)	20-23 (+3)	7	Able to recognise personal achievements although goals not fully met will continue to work on them as much as possible in the context of ongoing challenges
4	F	29	P	Loss of desire	1	Adverse extended family living conditions	33-34 (+1)	16-26 (+10)	6	Minimal progress towards goals. Refer on for couple communication
5	F	23	W	GID & Sexuality	10	2 episodes of self-harming	29-24 (-3)	5-9 (+4)	7	Minimal progress towards goals Recommended referral on for weekly psychotherapy
6	F	31	W	Vaginismus	9	PTSD following SA at 13yrs old.	35-32 (-3)	8-21 (+13)	7	Continuing to 2nd contract
7	F	27	W	Vaginismus	8	Previous DV in early twenties relationship	28-14 (-14)	10-2 (-8)	5	Goals largely achieved. Reports she can now have SI without the fear of pain
8	M	32	W	GID	18	Mother died when he was in early teens	54-52 (-2)	0-3 (+3)	7	Making progress towards goals. Referral on to GIC.
9	M	46	B	ED, 2ndary delayed ejaculation	3	Severe financial difficulties	52-46 (-6)	7-6 (-1)	7	Goals largely achieved

Warwick & Edinburgh Mental Wellbeing Scale (WEMWBS) deteriorated score (≥ -3). Patient Health Questionnaire (PHQ-15) deteriorated score ($\geq +2$). Ethnic group: White (W), Other White (OW), Pakistani (P), Black (B). Domestic Violence (DV), Sexual Assault (SA). Post-traumatic Stress Disorder (PTSD), Gender Identity Disorder (GID). Sexual Intercourse (SI). Gender Identity Clinic (GIC).

Service user experience of therapy and personal outcomes are explored (6.6) providing an interesting wider view to further broaden an understanding of the limits of validated measures of change alone in assessing the effectiveness of an intervention.

6.6. Experience of therapy

Finally, the service-wide patient feedback survey has been a vital source of data ensuring patient influence over service development and has contributed to continued service-commissioning (Penman, 2009). Following team reflection and planned action, the numbers of Client Feedback Survey (CFS) returns increased from 31% (N=55) in 2006 to 50% (N=90) in 2015. This means that just under 50% of those accepted into the service (PSCS) did not return their CFS which must be taken into account when reviewing the results. The CFS results carry an element of potential bias as a consequence (Tables 6.viii-6.ix).

Therapists within the service now give the CFS to the individual, by hand, at the end of therapy. The questionnaire is explained and completed by the patient, in privacy before leaving the premises, or if preferred returned by post within the following 2-3 days. Those who end therapy early are sent the survey by post with a stamped addressed envelope for return within the following 7 days. At present, it is not fully understood why half the service users do not take the opportunity to share their views of the service. This may be taken forward as an exploratory action by the local team. Since 2009, further adaptation of the CFS (Appendix 1) has been made through an informal process of staff consultation and observation of use in practice.

Data from the service-wide Client Feedback Survey (CFS) 2014-2015 (N=90) is shown as experience of therapy by

- Subjective change in distress or worry relating to the reason for referral –before and now

- Confidence in handling the problem now
- Alliance with the therapist
- Overall satisfaction with the service
- Recommendation of the clinic to a friend or relative

Of those who were offered the feedback survey (N=178), half (50%) returned their feedback on the service. Of these (N=90), 75% (n=65) were White, 7.8% (n=7) Other White, 10.1% (n=9) Asian, 5.6% (n=5) Black and 3.3% (n=3) 'Other ethnicity' Arab, Iraqi and Chinese.

The Likert scales ratings (1-7) were analysed by percentage scores of respondent answers (N=90). This gives an indication of changed self-rating in coping, alliance with the therapist and user experience of the service. Changes over time in the Likert scale responses from the CFS (N=90) concerning individual self-assessment are presented (Table 6.viii) followed by their subjective experience of the therapist (Table 6.ix) and experience of the service and recommendation.

The results of the CFS in terms of identification of a minimal clinical important difference (MCID) (Tables 6.viii-6.ix) and the personal goal attainment of the four depth cases (8.7 & Appendix 14), are contextualized by Jaeschke, Singer and Guyatt, (1989). Jaeschke et al., found that a 0.5 change on a 7-point Likert scale is an acceptable and meaningful change threshold. However, differences of 1.0 have been shown to represent 'moderate change' and greater than 1.5 represented 'large change' (Juniper et al.,1994). The latter authors reported that the minimal important difference was similar to other evaluation instruments showing consistency across domains for improvement as well as for deterioration. Using these thresholds, self-assessment at the end of therapy is evaluated (Table 6.vi): i.e. a change in one point on a seven point Likert scale represents 'moderate' change and 1.5 or more represents 'large change' (Juniper et al., 1994).

The results demonstrate that overall (N=90), on the measure of change in trouble, worry or distress over time in therapy, 74% (n=67) experienced large positive change, 10% (n=9) experienced moderate change and 16% (n=14) of these patients reported that they experienced no change over the course of therapy. Furthermore, 71% (n=64) of responders indicated by the end of therapy, that they were satisfied to very satisfied with their ability to handle the problem that brought them into therapy. Comparative figures with other psychosexual therapy services were not available due to the complexity in the design of valid outcome measures for psychosexual therapy (Twigg & Mellor-Clark, 2013). A breakdown of responses by intervention modality is therefore given for intervention comparison within Table 6.viii) as brief psychodynamic principles (BPP) and behavioural principles (Behav.) The number of sessions completed by the responders was not included in this report and these would be helpful to include in such reports in the future.

The breakdown of service responders shows (Table 6. viii) some differences between the types of therapy modality experienced. A difference is clearly evidenced within this service delivery between the self-perceived outcomes in relation to their problems. A 19% greater improved sense of autonomy over the issue that brought them into therapy is found from the responders who experienced the use of brief psychodynamic principles during the therapy. This tentatively appears to align with the lower rate of engagement to a full therapy contract of those who received the therapy with greater focus on behavioural interventions (Table 6.vi). This, with caution, confirms the literature findings (Chapters 3 and 4) of short-term or brief psychodynamic therapy, that patient satisfaction with the intervention is here aligned with a sense of greater personal autonomy in relation to their persistent symptom and relief of personal distress.

Table 6.viii) Client Feedback Survey: self-assessment

How would you rate the trouble, worry or distress your problem(s) caused you when you first came to our clinic?						
Likert scores 1-7: 1 no problem to 7 severe						
Likert scores	% in category			(n=)		
	All	BPP	Behav	All	BPP	Behav
All responders	100	54.4	45.5	(90)	(49)	(41)
1-3	8	6	12	(8)	3	5
4	11	10	15	(10)	5	6
5-7	80	84	73	(72)	41	30
How would you rate the trouble, worry or distress your problem(s) cause you now?						
1 no problem to 7 severe						
1-3	74	82	63	(67)	40	26
4	10	8	15	(9)	4	6
5-7	16	10	22	(14)	5	9
Problem improvement: How satisfied are you with your ability to handle the problem(s) that brought you to therapy?						
1 very dissatisfied to 7 very satisfied						
1-3	8	6	10	(7)	3	4
4	21	14	29	(19)	7	12
5-7	71	80	61	(64)	39	25

Although the PSCS internal audit in the following year (2015-2016) showed a raised 77% (n=53) of survey responders were satisfied with their ability to handle their problem by the end of therapy, there were 10% neither satisfied nor dissatisfied and 13% dissatisfied with their ability. This suggests again that there are a minority of service users represented who do not experience a greater sense of autonomy over their presenting symptom (Table 6.viii). This finding is in contrast to the service-user assessment of their therapist (Table 6.ix) demonstrating satisfaction of ≥93% in all 'alliance' categories with just 1-2% falling into the categories of dissatisfied to very dissatisfied in alliance. This 2% could relate to survey completion error. Nevertheless, a strong positive alliance is shown across the therapy modalities.

Table 6.ix) Subjective experience of alliance with therapist

How satisfied are you with your Therapist(s) in relation to: **Understanding your problem(s)**						
Likert scale 1-7: 1 being very dissatisfied-7 being very satisfied						
Likert scores	% in category			(n=)		
	All	BPP	Behav	All	BPP	Behav
1-3	2	0	5	(2)	0	2
4	0	0	0	(0)	0	0
5-7	98	100	95	(88)	49	39
How satisfied are you with your Therapist(s) in relation to: **Caring and warmth.**						
1 being very dissatisfied-7 being very satisfied						
1-3	1	0	2	(1)	0	1
4	2	0	5	(2)	0	2
5-7	97	100	93	(87)	49	38
How satisfied are you with your Therapist(s) in relation to: **Respect for your opinions and feelings.**						
1 being very dissatisfied-7 being very satisfied						
1-3	2	0	5	(2)	0	2
4	0	0	0	(0)	0	0
5-7	98	100	95	(88)	49	39
How satisfied are you with your Therapist(s) in relation to: **Knowledge in the special area of sexuality**						
1 being very dissatisfied-7 being very satisfied						
1-3	2	0	5	(2)	0	2
4	4	4	2	(3)	2	1
5-7	94	96	93	(85)	47	38

The two remaining responses to the routine survey questions regarding the experience of the service as a whole (N=90), 96% (n=85) of respondents stated that they were satisfied to very satisfied with the service with 99% (n=88) of respondents stating either ‘yes’ or ‘yes definitely’ that they would recommend the service. Taking account of the PSCS 50% return rate, and the lower respondent rate (6%) from the IAPT LTC/MUS intervention, a similarity was nevertheless found in patient experience of their therapist and of the service which confirmed high satisfaction rates (De Lusignan, Jones et al., 2013*).*

6.7. Summary of findings

The preceding chapters demonstrated the importance of generating practice based knowledge to further build programme theory of what works for whom and in what circumstances for addressing PPS by psychological therapy. The use of the routine service outcome measures, by and large, met the recommendations of the intensive systematic psychotherapy case study protocol (McLeod and Cooper, 2011). However, an independent participant interview post-therapy, suggested by the protocol, was not given ethical permission in this particular evaluation setting. Nevertheless, the data emerging from this insider-Realist Service Evaluation methodology builds upon Fishman's further emphasis on an enrichment of McLeod and Cooper's psychotherapy case study protocol, to accrue new knowledge for clinical guidance (Fishman, 2013).

This chapter has contributed to answering the questions posed for Part I of the data analysis (5.3.1.) in achieving the planned quantitative data analysis. Six major findings have emerged and their main points shown by grouping.

1. The socio-demographic nature of the PSCS user population

Male PSCS users were discovered as the majority compared to a contrasting female majority engaging in wellbeing services for anxiety and depression. The PSCS cohort (2014-2015) is found in alignment with the overall ethnicity of the population it serves, but is under-represented by the over 65 age range. The service users at baseline were found to be below the population average for mental wellbeing, with a history of persistent sexual symptoms not improving over time nor by medical intervention.

2. A high incidence of PPS within the PSCS population

The routine use of the Somatic Symptom Severity questionnaire (PHQ-15) showed that 70% of those engaging with the PSCS had *other* persistent, non-pathological physical 'dysfunction' over a third of which significantly reduced over time in therapy.

3. The alignment of persistent sexual symptoms to the parameters of PPS

During this realist evaluation of the literature (Chapters 3 & 4) and from the quantitative findings, Persistent Physical Symptoms (PPS) have not been found caused by any known pathological or age-based disease processes. PPS do not recover spontaneously over time, but rather may deteriorate over time. Such unremitting symptoms are not found to make recovery by routine medical intervention. These parameters also aptly describe the nature of the persistent sexual symptoms found in the PSCS population and evidenced in this chapter. However, persistent sexual symptoms are rarely included in somatic symptoms scales in current usage (Creed et al., 2011; Burton, 2013), supporting the need for further research in this area.

4. The discovery of lowered mood and a moderately significant negative relationship between possible depression and somatic symptom severity

Thirty-seven percent of PSCS users within the caseload of study were found with 'possible' concurrent depression (n=28) and a further 11.39% 'at risk' of depression (n=9), making the observation and care of depression as well as addressing somatic symptoms within psychosexual and general therapy, of clinical importance. Important and reliable change in mental wellbeing was found over time in therapy. However, of those with high wellbeing (n=42), 50% were more likely to be found with mild somatic symptoms, with a lesser 14.3% experiencing moderate to severe somatic symptoms. Of those in the lowered mood group (n=9), but not

clinically depressed, over half (56%) were found to have moderate to severe somatic symptoms and of the 'possibly depressed' group (n=28), over half (61%) had moderate to severe somatic symptoms. The findings prompt healthcare professionals to be mindful in practice of fluctuating states of mind and body. It is important to offer a holistic and flexible approach to the individual with at least one PPS regardless of whether this is found comorbid with depression or high wellbeing.

5. The brief psychodynamic interventions show higher levels of engagement to the end of therapy

Two within-service therapy caseloads (using brief STPP or focused more on CBT principles) were compared by intervention, outcomes and engagement. Results were given in terms of 'reliable change' (HSCIC, 2015) with broad equivalence, although, due to the small numbers the behavioural intervention appeared to have greater improvement in somatic symptoms by the end of therapy. Another perspective is given by the Client Feedback Survey results found at section 6.6. and below. However, the brief STPP intervention over a full course of therapy (n=33) showed a 53% rate of engagement in therapy versus a 20% (n=9) rate of engagement using a predominantly CBT approach. This supports previous research findings that STPP has comparatively higher engagement rates than controls or CBT interventions, therefore tentatively suggesting the brief psychodynamic psychotherapy intervention acceptability (Abbass, Kisely and Kroenke, 2009).

6. Validated outcome measures of 'reliable change' gave only a partial view of the subjectively experienced engagement in therapy

Equal to or above 92% of service users who completed the survey reported high satisfaction with the service, high positive alliance with the therapist and significantly reduced distress. 'Important' improved confidence relating the resolution of the reason for referral was shown

across the service respondents. This Service 'Client Feedback Survey' (CFS) (N=90) reveals the subjectively experienced impact of therapy in reference to the primary reason for referral more comprehensively than changes recorded by validated measures of the wellbeing and somatic symptom severity measures alone. Although this finding might be dependent on the nature of those (50%) who chose to complete the survey, it is of interest to note the reduced distress and improved confidence concerning their PPS presentation by the end of therapy with comparison by the intervention experienced. Of all CFS returns, there was a good representation of each type of therapy experienced with high positive alliance with the therapist across all. However, from those who had experienced a brief STPP intervention there was a 19% greater personal reduction in stress or worry and improved confidence in personal ability to handle the presenting unresolved physical symptoms in comparison to those who had experienced the CBT intervention.

Furthermore, the examination of nine cases of 'reliable deterioration' within the two contrasted within-service caseloads showed their individual complexity. A third of these cases were from the CBT caseload and two thirds from the STPP caseload. Tentatively, a possible greater depth of therapeutic engagement facilitated by the brief STPP intervention can be seen. However, the examination found at the end of a first contract of therapy that despite 'reliable deterioration', personal goals for therapy could still be met (n=3), two were referred on, two moved into to a second contract of STPP therapy and one was satisfied that she had explored her issues at depth with STPP, without fully reaching her goals. All nine acknowledged that they valued the experience of engaging with the therapy intervention.

The data analysis within this chapter has exposed some important findings and the subsequent comparisons between STPP and CBT caseloads are of interest and could be further explored in the future but for now, are necessarily interpreted with great caution. However, the purpose of this

study is to focus on what works and how for individuals presenting with heterogenous PPS, using core STPP principles (Shedler, 2010; Irwin, 2009). Prompted by the literature synthesis (Chapters 3 and 4), it was recognised that common factors are used across therapy modalities for effective PPS interventions in real-world practice and that this also applied to the author's own clinical intervention.

Therefore, the findings in this chapter have not only contextualised the service delivery for the future transferability of findings at service level, but indicate the importance of exploring the process of this brief STPP intervention with its enhanced rates of engagement and patient satisfaction with their achievements. The engagement with cognitive-behavioural perspectives that are relevant to the resolution of PPS *alongside* the briefly applied STPP core principles found flexibly applied in practice was acknowledged in Chapter 4. The cross-modality themes of engagement shown to be effective with PPS are therefore further developed and used for the qualitative data analysis in Chapter 7.

Chapter 7: Qualitative Analysis: Development and Findings

7.1. Introduction and aims

A Realist Evaluation explores what works for whom and in what circumstances (Pawson and Tilley, 1997). The results of the previous chapter concerning service delivery, demographics and change measures of somatic symptoms and wellbeing, provide a broad context for the following in-depth qualitative data analysis of therapy process and outcome concerning persistent unresolved physical symptoms (PPS). This chapter confronts the content of the therapeutic engagement during the process of therapy. Also, the abductive analysis of therapy transcripts against a theoretically derived analytic framework addresses the latter objectives of Aim 3 of the thesis (1.1.). Context, mechanism of change and outcomes are critically and reflexively examined at case and cross-case levels for themes of engagement and exceptions. This material is further mined in case-reflexive detail in Chapter 8.

Here the reflexive insider-Realist Service Evaluation (ri-RSE) Methods found in Chapter 5 are put into practice in relation to ethical recruitment of participants for the examination of engagement with PPS through therapy. The planned qualitative data collection, facilitating the reflexive function into action and analytic stages 1-4 are shown with the distillation of the themes of engagement with PPS.

7.2. Qualitative data collection

Aim 3 of this realist evaluation was to further develop knowledge of ‘how’ and to what effect the adult patient and therapist engage in the exploration of the persistent physical symptom(s) (PPS) for the extraction of principles

of engagement. The plan was to consecutively recruit up to 8 patients (Hill,1989) referred over a period of two months into the service and taken into the Therapist-Evaluator's (T-E) caseload. McLeod (2012) studied her own Transactional Therapy interventions for the prospective study of three consecutively referred patients with long term physical conditions opening the way for a means of relatively unbiased prospective case selection.

This recruitment of 8 consecutively referred cases initially to examine the first two and the last therapy sessions were reduced to 6 through drop-out. The reflexive process facilitated further critical thought and discussion regarding a decision, at that stage, as to how best to proceed (see para 7.2.4.).

7.2.1. Ethical recruitment

The consent process was devised by an iterative consultation to secure the minimisation of potential harm through ensuring privacy, the protection of the service review personal data by removing personal identifiers such as name, address and data of birth and by endeavoring to maintain participant autonomy at all times. These ethical concerns, particularly in the questionable concept of facilitating a fully informed consent process with the psychotherapy participant (Edwards, 2010; Levine and Stagno, 2001) with continued consent to publication are discussed in the Methods chapter (5.2 and 5.5).

Selection was defined over a two-month period. During this said period, the first nine of new patients who met the inclusion criteria were extended an invitation to become involved in the service review. In view of the above concerns and the sensitive nature of the service, the discussion with new patients regarding the proposed service review was undertaken in privacy by the T-E shortly before the assessment session (see Chapter 5.5.). This was to ensure that that no-one else, apart from the T-E, within the service or outside it would be able to identify them as participants. The Participant 'Service Review' Information Sheet (Appendix 7) was used

firstly as a basis for talking through the participation process and to respond to any questions. Open discussions were conducted regarding any concerns, with the participants being given the option to change their mind at any time without having to give a reason. It was also assured to them that throughout, their therapy would continue as normal, even should they withdraw from the review. In the latter instance, all previous audio-recordings would be securely deleted and that this would not impact their access to therapy in the future. The potential participants were given time to review the consent form point by point and offered an alternative contact if they wished, at any time, subsequently to withdraw without having to give a reason. If they consented, they were given a copy of the information sheet and the consent form and encouraged to re-read them at home so that any concerns arising could be addressed either with the T-E or the line manager if they so wished. The decision to consent or not was made before the first therapy session began.

In the role of T-E there was initial professional concern regarding the impact of requesting an audio-recording of each therapy session of sensitive material. However, the potential participants were advised of a confidential and secure transcription process in the context of the long history of audio recording therapy sessions within counselling and psychotherapy supervision, training and in medical practice (Bond, 2004; GMC, 2011). They were also advised that recordings could be stopped at any time within a therapy session at their request. At this early stage all of the potential participants continued with the ethically devised consent process (See Chapter 5.3.2. and 5.5 with consent flow chart Fig. 5.1). With this process, involvement was readily agreed by all but one of those invited to participate.

7.2.2. Drop-outs

The one decline, was from a female Asian, aged 21-25, who declined involvement immediately, saying that she wanted her therapy to be private between herself and the therapist and not shared with anyone else. In addition to being given the assurance that her name could not be linked to any data taken (only by the therapist-evaluator) and she was also made aware of the potential for her to discuss any short verbatim extracts selected for publication to make sure she was comfortable with their use. But she felt this to be too much of an exposure to deal with and continued to decline to give consent. Her therapy continued as normal.

The consented data gathering process continued through the therapy contracts over the next seven months. During the study, one previously consenting white male aged 36-45 (KB) withdrew his consent after returning from work abroad to continue in therapy three months after his initial assessment. In the role of T-E, and as therapist I observed some hesitance as I verbally renewed his consent and after some discussion, we agreed to the withdrawal of his audio-recorded data and continuance as a participant. In addition to the above case, data of a second white male aged 56-65 (UN) was also withdrawn due to medication-related complexity. His case no longer met the criteria for inclusion (see exclusions in Chapter 5.3.2.ii.).

7.2.3. Transcribing

For the transcribing of the therapy transcripts, the research-lead within my employer/sponsoring organisation offered to facilitate a doctoral student to undertake the therapy transcriptions. The T-E proposed that as the study was using a theoretical frame in which to examine how engagement with PPS took place in therapy, certain emotional expressions of the participants would be indicated in brackets on the relevant line of text. These would include, that is in broad themes, laughter, a few second pause or tearful response, which could be heard.

There was a 4-5month delay within the employing organization in the process of ordering and receiving a laptop and the Dragon Nuance Dictate transcribing software whilst the data was being gathered. By the time the equipment was in place, the doctoral student (RG) transcriber was only able to undertake one transcription a week at most (planned at that stage n=24, 8 therapies x3 transcripts). An administrator (MY) from the clinical research unit volunteered to assist, sharing the same password protected laptop and transcribing software with (RG) with the same instructions. To ensure data confidentiality during this sharing of laptop for transcribing purposes, agreement was made on safe transfer of data via the university password coded 'drop-box' facility. Also, a one-off transcription was undertaken by (JR), a senior data analyst within the organisation. This pragmatic and reflexive decision for managing the quantity of data within the time constraints had to be made, to avoid any further delays.

7.2.4. Reflexive decision-making regarding final case selection

For the evaluation, after drop-outs and exclusion, 6 therapy cases remained. Due to unexpected delays in obtaining the transcriber equipment as mentioned above, the process started slowly but in earnest in January 2015. With continued unexpected delays, it was decided to take a decision on the direction the analysis would take. As per the initial start, nine transcripts had been undertaken by the transcribing team.

The options were to:

a) continue with the six therapies' transcripts taking the first two and last therapy session for analysis (n=18)

b) take the first 3 transcribed whole therapies for full analysis (n=16)

This was discussed with my academic supervisors and consequently, a process of reflexivity using the Driscoll (2007) Model (see Chapter 2.6.3) was undertaken:

What: A decision was needed due to loss of time: either to transcribe and analyse the first two and the last session of therapy across all six therapies remaining to maximise the spread of findings, or to take the first three full transcripts of therapy for depth analysis.

So what? After extensive deliberation, it was decided to perform an in-depth analysis of the first three full therapies transcribed in alignment with samples of systematic psychotherapy case series studies (McLeod and Cooper, 2011). Both retrospective and prospective examples (Hersoug, 2010; McLeod, 2012) had made depth comparisons of 1-3 cases.

Now what? In the eventuality, I was able to undertake several transcriptions myself and to expand the data to four full therapies of varying lengths (n=23). The content of these four therapies were then analysed against the preliminary theoretical analytic framework by abductive qualitative analysis.

In the qualitative analysis individual cases are given enough demographic detail to draw conclusions but specific details were withheld to ensure that they are not individually identifiable or recognised by anyone other than themselves and the author (see Table 7.1.). This detail includes disguised information regarding relationship, age, gender, primary and secondary persistent sexual symptom, symptom duration, current medication and relevant history, broadly outlined by the CORE-Assessment Form (Chapter 5.6.4.) and relevant to the analysis. The participants are introduced in Table 7.i). Individuals are given research IDs. Age is given by age range and relevant past medical history is given in broadest terms.

Table 7.i) Demographics of the four depth cases (PSS=persistent sexual symptom)

Research participant ID & demographics	TN living with medium term partner	TG with no current partner	SQ with very new partner	BX living with long term partner
Age	26-35	46-55	26-35	46-55
Gender	M	F	M	M
Ethnicity	White	Other white	Asian	White
Presenting primary PSS & length of history	Primary (PE) Premature Ejaculation 5-10 years	Primary anorgasmia 31-45 years	Primary PE, performance anxiety 5-10 years	Primary ED 21-30 years
Presenting secondary PSS & length of history	Secondary ED, loss of orgasmic feeling 1-4 years	Choosing felt-inappropriate partners 5-10 years	Secondary ED, severe lack of arousal 1-4 years	Performance anxiety, long periods of low sexual desire 11-20 years
Reason for current medication	10 years of preventative treatment for a condition diagnosed in teens	None	3-4 years of gastric reflux treatment	2 years for management of … disease and 6 month treatment of potentially life-threatening illness
Previous mental health interventions	Five session brief counselling intervention 4 years previously	No uptake of previous anti-depressant medication or bereavement counselling	None	None

7.3. Stage 1: Developing the preliminary analytic framework

The phases in the development of the preliminary analytic framework are extensively outlined in Chapter 5 (5.10-5.11). In this chapter the realities of real-world practice are shared. The outline for an analytic framework from preliminary theoretically based themes derived from the literature (Table 5.vii) is repeated below as Table 7.ii) landscape format, against which themes are further defined through a process of 'open-coding' (Table 7.iii).

Also, on receipt, the transcripts that were undertaken by the employing organisation transcribers, including MY, RG, one by JR were checked for accuracy. The T-E undertook to transcribe over half the audio recordings to minimize the time delay because of resource pressures, in total there were 23 hour-long digital MP3 recordings. This meant that the therapist-evaluator became very familiar with the data.

Table 7. ii.) The initial preliminary theoretical analytic framework

Preliminary Themes	Definition of terms
THERAPEUTIC ALLIANCE	Generating hope, empathic response, joint enterprise
DEVELOPING A FOCUS/GOALS FOR THERAPY	Generating goals, nature of those goals
USE OF SYMBOL AND METAPHOR	Use of evocative language, symbol and metaphor to capture the significance of previous experiences
SENSITIVE ATTUNEMENT	Making only tentative interpretations, creating the opportunity for the individual to disagree
FACILITATING EXPRESSION OF EMOTION	Conditions leading to the expression of strong emotion
DEVELOPING COGNITION IN RELATION TO EMOTION AND THE PMUPS	Working within the therapy relationship to understand the emotion in relation to the PPS
BEHAVIOURAL INTERVENTIONS/RESPONSES	New or different actions
OTHER THEMES OBSERVED NOT INCLUDED IN THE THEMES ABOVE	All other qualitative data here, for further coding and analysis

Seven themes were originally selected with an opportunity for the contribution of unexpected findings.

Ritchie and Spencer's (1994) open coding format was used to familiarise with the data against the pre-conceived themes of engagement: two therapy transcripts were examined line by line, this resulted in the generation of 26 codes relating to engagement. These open codes were checked against two further transcripts and the codes were reduced from 26 to 15 and then, on a third round of scrutiny, to 9 codes. This process led to further development and refinement of the themes of engagement with PPS (Table 7.iii).

In this process, following Ritchie and Spencer's (1994) open coding guidance, the transcript was central to the page. The process that followed included showing the on the left hand side the preliminary open coding (see sample, Table 7.iii and remainder at Appendix 16) in the transcripts as they were re-read as illustrating the nature or purpose of the engagement observed within the text. Further, in right hand column, manual open-coding notes were made on how the therapist-patient engagement took place. This was noted as a type of therapist question or comment and as the patient response to it, and in the far right column, the outcome observed.

At this stage, the open coding summary led to the creation of nine open codes and their content. Samples i-ii are shown in Table 7.iii) with the remaining open codes iii-ix illustrated in narrative form at Appendix 16.

Table 7.iii) Open-coding on the engagement process with PPS

**Th: denotes therapist verbatim intervention and response*; Pt: denotes participant/patient verbatim interjection and response.
The remaining open coding process is found in narrative form (see Appendix 16).

Open coding	Verbatim extracts	Means of engagement observed in the transcripts	Outcome observed
i) **Offering an open invitation to engage**	Sample A **Th: … to hear in your words then, what's brought you here today? And what sense you make of what's happening to you so far?* Pt: Okay, so what's brought me here today I suppose is 2 years ago now, I started, I suppose my…	What are your words, your understanding? Why now? When/how?	Free-flow of brief history, some detail and context, facilitating the avoidance of therapist presumption on the case
ii) **Invitation to expand on story**	Sample B *Th: What is it like then?* *Pt: So, again, err… it's err until 6 months ago it was fine, so I wasn't having trouble getting a hard erection. Err and now yea even I struggle, just yea* *Th: To get an erection?* *Pt: Yea yea* *Th: For yourself?* *Pt: Yea by myself yea* *Th: Okay, can you do it?* *Pt: I can* *Th: but its hard work?* Sample C *Pt: But a part of me is searching for something…* *Th: longing?* *Pt.: yes, yes – frustrated because I know I should be…* *Th: is that feeling similar to a feeling you had when you were younger?* *Pt: yes* *Th: longing for something, looking for something?* *Pt: yes, and that's what's coming back (tearful)*	Following patient information-going with it Looking for more detail Clarifying the nature of the main presenting PPS-in what ways does this happen? Taking it back to when it started, to the time before the PPS began Taking it back to childhood What does he/she want now?	Further detail, greater therapist awareness of depth/unique nature of problem, starts to give direction for goals

7.3.1. Findings of the open-coding process

In the evaluation analysis, the open-coding and content, with engagement in mind, were checked against the preliminary theoretical analytic themes. Then, the content of the seven original theoretical themes were enhanced with the open-coding findings above. I found that four new themes emerged from this stage of the analysis, particular to engagement with PPS as follows.

After re-immersion in the developed coding, the new theme, called: 'Exploring the nature of the PPS' was added to the preliminary theoretical framework. It included the following content:

- the patient relationship to the PPS (perception and experience of the PPS)
- the impact of the PPS on relationships
- the influence of medication/organic dysfunction
- exploration of predisposing, precipitating and perpetuating factors

Alongside this, 'Therapist Reflexivity'. The mechanism of therapist reflexivity on the process of a mutual engagement with the PPS between therapist and patient appears integral to the engagement. From the transcripts, this included therapist scanning in relationship to the PPS, for:

- repeated patterns of response to self and others
- patterns repeated in the therapy relationship
- core conflicts/previous wounding
- defences or blocks to exploration (therapist and patient)
- emotional 'hot' spots
- lack of emotion

The reflections on the issues mentioned above helped to direct the exploration of the participant relationship to the PPS back into the live therapy relationship, thus shedding further light on pre-disposing,

precipitating and perpetuating factors. These factors are further explored later in Chapter 8. Initially these observations were gathered under the theme ‘Therapist reflexivity’.

I observed the developing change in perception and relationship to the persistent sexual symptoms over time in therapy and this became a new theme, ‘Developing experiential change’. Moreover, as I observed across all the transcripts, the fourth new theme emerged as generating ‘Awareness of acceptability (or not) of the intervention’; both therapist (Th) and participant/patient (Pt) awareness of this appear to be of value in continuing the engagement with PPS in therapy.

The revised theoretically based preliminary analytic framework shows (Table 7.iv), how the elements of engagement from the open coding were absorbed in the definitions of the original seven themes with a further 4 developed preliminary themes. This shows the framework development from the original at Table 7.ii).

Table 7.iv) The developed preliminary theoretical analytic framework
showing the added themes (*) and definitions (+) following open coding.

Preliminary Themes	Definition of terms
THERAPEUTIC ALLIANCE	generating hope, empathic response, joint enterprise +Affirmation, + Open invitation to engage
* Exploring the nature of the PPS	+the patient relationship to the PPS, +the impact of the PPS on relationships +influence of medication/organic dysfunction, +summarising the nature of the PPS +pre-disposing factors, +precipitating factors, +perpetuating factors
* Therapist reflexivity	scanning in relationship to the PPS, for +repeated patterns of response to self and others, +patterns repeated in the therapy relationship +core conflicts, +emotional 'hot' spots +lack of emotion, + noting patient and therapist defenses
+GOALS/FOCUS FOR THERAPY	+generating goals, +nature of those goals +working on goals, +evaluating goals
USE OF SYMBOL AND METAPHOR	use of evocative language symbol and metaphor to capture the significance of previous experiences +in relation to the PPS,+ initiated by patient +initiated by therapist, +using 'what if….' to challenge preconceptions
SENSITIVE ATTUNEMENT	making only tentative interpretations, creating the opportunity for the individual to disagree + in relation to the PPS, +use of non-judgemental, accepting attitude (moves beyond mindfulness to consider: why has this PPS developed?)

Preliminary Themes	Definition of terms
Table 7.iv) cont. FACILITATING EXPRESSION OF EMOTION	conditions leading to the expression of emotion (the word 'strong' is removed 7/4/15 as it is not always felt as 'strong' in the therapy transcripts or by therapist reflection)
DEVELOPING COGNITION IN RELATION TO EMOTION AND THE PPS	working within the therapy relationship to understand the emotion +linked to the PPS, +challenging, use of 'what if…' +shows that the patient can begin to develop choices in reaction and response to self/others/PPS
BEHAVIOURAL INTERVENTIONS/RESPONSES	new or different actions +making different choices
*Experiential change	+ alteration in perception and experience of PPS, +alteration of perception and experience of self and others, +feelings about goal achievement, +subjective response to the relationship between measured well being and persistent symptom severity
* Acceptability of the intervention	+subjective view of therapy

Additionally, to ensure credibility and minimisation of bias in the evaluation, this development of themes and coding of interventions was checked and validated by consultation with an academic supervisor (Senior Researcher in Health Psychology) and academic auditor (Director of Studies). After the first round of coding in NVivo 10 (see 7.4.1.), the theme 'Exploring the nature of the PPS' swallowed up the theme 'Goals for therapy' as the exploration of the nature of the PPS led towards goal development and vice versa. Moreover, goals for therapy were more efficiently explored using the Goal Assessment Form (5.6.5) and are reported (8.7.1).

7.4. Analytic Stage 2: Using qualitative data software

At this stage, the selected 23 therapy transcripts were uploaded into the NVivo 10 software package within which I could undertake further abductive analysis against the enhanced themes. NVivo 10 version for Widows was installed under university licence onto a university laptop to assist data analysis. The NVivo software is managed by 'qsrinternational' who claim to have 1.5 million users. The software enables researchers to collect, organize and analyse content from interviews, focus group discussions, surveys, audio, social media, videos and webpages.

For usability and ease of data interpretation, each numbered therapy transcript, by participant research ID, were created as sources. Also, the three extra themes were added to the preliminary theoretical framework as nodes.

- Therapist reflexivity
- Experiential change
- Acceptability of the intervention

The fourth,

- Exploring the nature of the PPS was combined with developing 'Goals for Therapy'

Table 7.v) shows the ten developed themes. Their properties are found in Table 7.iv).

Table 7.v) Developed themes of the preliminary analytic framework

Nodes	Themes
1.	Therapeutic Alliance
2.	Exploring the nature of PPS/goals for therapy
3.	Therapist reflexivity
4.	Use of symbol and metaphor
5.	Sensitive attunement
6.	Facilitating expression of emotion
7.	Developing cognition in relation to emotion and the PPS
8.	Behavioural interventions and responses
9.	Developing experiential change
10.	Checking for intervention acceptability

These 10 themes were represented as parent nodes in NVivo.

7.4.1. Trouble shooting in NVivo

My reflexive, analytic memo records that the upload of the data felt complex and not as responsive as the brief NVivo trainings undertaken had implied. The trainings that I had undertaken in preparation to use NVivo were:

- online training resource through qsrinternational
- University NVivo training group session
- 1:1 training with my second academic supervisor prior to the data upload being ready and at the beginning of data upload

For trouble-shooting purposes, I looked for guidance within the qsrinternational support page. However, the generic instructions did not

provide me with understanding of what I might have already done in error. Causing time delay, I found that I had to repeat the first stage of analysis within NVivo three times. At one point, over a 48hour period all data appeared to be lost. The loss equated to the previous nine days of analytic work. Finally, with the help of two separate 'qsr' trainers of an hour each, against their own expectations, the data was retrieved. However, by that time the UK qsr advisor helped me to understand why the system kept 'crashing' with subsequent loss of data. I had uploaded a transcript with line numbers which had caused the problem in NVivo's function.

7.5. Analytic Stage 3: Populating the themes

Post exhaustive training and expansive use of the software, the third attempt at the analytic coding within NVivo was faster –themes as nodes were given subthemes (daughter nodes) as observed in the transcripts and populated with verbatim extracts. Moreover, higher distillation of the content of themes was carried out at Stage 4.

In the software analyses, at this Stage 4, the ten themes were transferred into new nodes in NVivo 10 as 'higher themes content'. These were populated by a distillation of the Stage 3 populated daughter nodes as broadly illustrative of each theme. These were printed out and all the illustrative quotations re-read within each theme to look for pattern and exceptions. Using my analytic memos on each of the ten themes' content, rather than exceptions, I saw instead that the quotations illustrated phases of engagement within each theme.

The qualitative analyses and evaluation plan in the methods chapter (Chapter 5.8. Part II) was to scrutinise in depth the case data, in order to develop knowledge of the process and outcome of engagement between the patient and therapist with PPS exploring:

- how the patient and therapist engage with PPS in therapy

- the nature of the PPS and personal goals for therapy
- the subjective experience of any changes during therapy

The question of how the therapist and patient engage with PPS across the four whole therapies was found to be very taxing to answer point by point. I had to reflect deeply on how the data could be displayed effectively.

7.5.1. Reflexivity into action: verbatim extracts

Again, using Driscoll (2001/2007)/Rolfe's (1993; 2001) reflexive cycle (Fig. 2.2) I explored the following:

What? Each of the ten theoretically and empirically derived analytic themes were initially extensively populated with verbatim extracts from all therapy transcripts, which were then distilled into higher content by fewer verbatim extracts

So what? Qualitative analyses of psychotherapy case studies are generally displayed as verbatim extracts, by participants. This illustrates a particular aspect of a therapy intervention, such as patient reactions to 'immediacy' in (Kasper et al., 2008) or by comparison counts of an aspect of verbal intervention (Hill et al., 2008). Their findings are illustrated case by case by verbatim extracts of speech and by quantitative data display, on one particular type of intervention. In this evaluation, it is required to examine four whole therapy interventions for PPS and its impact on the severity of PPS and wellbeing, searching for cross-modality principles for practice. A selection of one or two verbatim extracts to illustrate each of the ten themes does not give justice, as therapist-researchers know, to the actual process of engagement.

Now what? I recognised that this issue served to illustrate the complex position of the therapist-evaluator, thus identifying the need to develop principles for practice but knowing that in the realities of practice, the process of engagement is interlinked and fluid. Plan: Principles shall be extracted from the content of the themes and illustrated from data across

the therapies. I follow this in Chapter 8 with my concurrent therapist reflexive memos of therapy process for each of the cases by session. These memos shall also be illustrated with verbatim extracts and shall show how observed events in therapy, through therapist reflection, are used to guide the patient and therapist towards achieving personal goals. By both these means in a qualitative but systematic manner, I address the questions 'how' the patient and therapist engage and 'to what effect'. The joint dismantling of the power of the predisposing, precipitating and perpetuating factors on the subjectively experienced PPS emerges through this process.

7.6. Analytic Stage 4: Higher content of Themes

In this section, tables of the ten themes, their sub-themes and illustrative content are given. Each table illustrating a theme with verbatim extracts is found at Appendix 15. A brief narrative outline of each is given below. This is followed by the summary tables of a higher abstraction of the content of the themes at para 7.6.2. (Tables 7.vi-xv).

Theme 1: Therapeutic Alliance

The higher abductive analysis within 'Therapeutic Alliance', (Table 7.vi) showed content that generates hope, exchange of information, invitation to expand on story and joint enterprise. These were instrumental in facilitating both patient and therapist to work through the unique content of the patient story and experience, adapting the process according to need. These findings are supported by the evidence of the basic Therapeutic Alliance embodied in the Likert scaling of the routine service 'Client Feedback Survey' outcomes (Chapter 6. 6.).

Theme 2: Exploring the nature of PPS with initial goals for therapy

The second theme, 'Exploring the nature of the PPS and initial goals for therapy' (Table 7.vii) was given extensive reference from the data collected. In each of the four cases evaluated in the study, there were

primary ‘sexual dysfunction’ conditions (see Table 5.i), that is, always experienced from the first consenting sexual relationship.

Theme 2 at Appendix 15, shows firstly the primary sexual difficulty, which is followed by illustrations of complexity in physical symptom presentation, i.e. further sexual dysfunction that is precipitated by life events. Additionally, predisposing factors reported by previous research into persistent medically unexplained symptoms (See Chapter 3.3) appear for three out of the four cases relating to early life stressors. Participant SQ, showed as an exception. Here, previous trauma was experienced in adulthood. This participant was seen for a shorter episode of therapy. He had, prior to engagement in therapy, experienced a poor response to Phosphodiesterase type 5 inhibitor (PDE5i) medication for his Erectile Dysfunction (ED) prescribed by his GP. For this participant, three therapy sessions over a period of five months ended with confident satisfaction at the restoration of sexual function without the use of medication (see Table 8.iii).

Precipitating factors in all cases were found to be different but appeared to open-up old wounds prior to engagement in therapy, prompting the individual to find help. In each case the experience of sexual dysfunction was getting more complex rather than better over time, causing the participants to seek medical intervention. Perpetuating factors revealed a commonality across all cases (discovered within Theme 2, Appendix 15). The content of the sub-theme of linked emotion although having similarities, were not an exact match to each other. However, on further reflection, the discovered emotions appeared to be linked by an overarching, unwitting loss of control over current (intimate) emotional connection, which was generated from the felt need to protect self or others (seen in the perpetuating factors) with an unexpected and unexplained loss of physical function. However, this reflexive finding was not obvious to the individual nor to the therapist at first. All four individuals were seeking greater satisfaction through improved sexual function, which,

in the event, could be facilitated by an improved emotional connection to themselves and to their partners.

Theme 3: Therapist Reflexivity

The therapist-researcher reflexive observations in relation to attitudes and responses around the PPS during the therapy process are distilled for the theme 'Therapist Reflexivity' (Table 7.viii). For example, what was the information that alerted the therapist's attention which had a possible relationship to the development or perpetuation of their PPS? The analytic observation of 'perpetuating factors' under Theme 2 'Exploring the nature of PPS' are mirrored in this theme. The selection of verbatim illustrations give an indication of 'here and now' moments that the therapist is considering as a potential 'hot-spot' indicator to tentatively revisit later in the therapy.

Analytic Stage 5 in the following chapter represents the inclusion of Freshwater and Rolfe's Type I and Type II reflexivity as concurrent reflexive memo-ing of observations of key issues on each case, session by session. This broadens an understanding of Theme 3. 'Therapist Reflexivity', showing the patient and therapist context and how the reflexive function was used in practice as a guide for the ongoing direction of the therapy.

Theme 4: Use of Metaphor

Within the theme 'Use of metaphor', I noted that when the patient used metaphor it communicated a depth of meaning to the therapist as a form of verbal 'shorthand' and enabled a direct expression of opinion which is shown across the content of the theme (Table 7. ix).

Theme 5: Sensitive Attunement

'Sensitive Attunement' looked for evidence of tentative interpretation within a safe enough environment for the participant/patient to disagree with the interpretation. It reveals an aspect of how the therapist's emotional

reactions to what has been said are shared, acknowledging and affirming the feelings that are generated by the patient story (Table 7.x).

Theme 6: Facilitating Expression of Emotion

During this stage of the analysis, Theme 6, described as, 'Facilitating expression of emotion' did not embrace all the data. During the evaluation, it appeared that a validation of emotion rather than 'expression' gave a more comprehensive term to what was happening during the therapies. There was evidence of emotional expression but also of facilitation to speak openly about previously unacceptable emotion and feeling. Subsequently, for the higher distillation, Theme 6 was renamed 'Validating Emotion' (Table xi).

Theme 7: Developing Cognition in relation to emotion and the PPS

As I approached Theme 7, 'Developing cognition in relation to emotion and the PPS' (Table xii) I noted that data from only one case had been used to populate this theme. This theme was found within the other themes as a continuous process, for example Theme 6, 'Facilitating Expression of Emotion' now renamed as 'Validating Emotion' and Theme 5, 'Sensitive Attunement'. 'Developing cognition' was found tightly woven into the therapy engagement and too complex to extract in isolation. I reflected on this and decided that it was enough to show a sample extraction to illustrate the interconnectedness of the themes of engagement within the analytic framework of this study. Cycles of growing self-awareness (cognition) are illustrated by the extracts within a first therapy session and illustrate as stated above, how the observations are closely aligned to other themes of engagement.

Theme 8: Behavioural Interventions and responses

This issue of the interconnectedness of the therapy engagement is again illustrated in Theme 8, 'Behavioural Interventions and responses'. It was important here to engage therapist-evaluator reflexivity on the data

analysis to see if this data could be extracted and placed within 'Behavioural Interventions' alone.

7.6.1. Reflexivity into action

The reflection on the engagement theme 'Behavioural Interventions and responses' is shown below.

What? As I worked through the data set within 'Sensitive Attunement' (See Theme 5), material emerged that was in effect, aligned to, as I saw it, 'Behavioural Interventions' in terms of addressing 'automatic thoughts' of Beck (1967) and Ellis' 'irrational beliefs' (1977). I would not personally use the CBT definitions with the intention of 'modifying dysfunctional thoughts', as Scott illustrates the use of Weissman and Beck's Dysfunctional Attitude Scale (Scott, 2009, p.42). This theme required careful consideration.

So what? The thoughts and emotional responses by the participants in these consecutively referred cases are interpreted here by the therapist-evaluator to be vital mechanisms for the purpose of survival. This is recognised by Woolfolk and Allen (2007) in their outline of Affective CBT for PPS. They mention in their exegesis of ACBT that the immediate emotional response to danger triggered by the perceptions of the amygdala before the cortex has been engaged, 'that occur outside conscious awareness' (2007, p. 51) is about survival. I reflect, in this brief intervention, that these automatic responses are, in the past, a crucial means of survival and in the present, not to be eliminated per se, or judged as dysfunctional, but to be valued and understood between patient and therapist.

Now what? The qualitative analysis was showing an emergence of the negative consequences of holding on to these self-protective survival patterns, and made clearer through the ongoing reflexive process of therapy as the patient and therapist engaged. I considered that facilitating an acceptance that these automatic responses are not a 'fault', gives the individual greater self-respect and frees him or her to make a choice for

change towards their goals for therapy (Skrine, 1997). Therefore, in order to broaden the bridge between CBT and Psychodynamic perspectives, I made the decision to draw this data from the theme 'Sensitive Attunement' to illustrate how perceptions can be changed. I do this in order to link back to one of the founding fathers of CBT, Beck's 'automatic thoughts' based on psychodynamic principles originally derived from psychoanalysis (Beck, 1967).

The distilled higher content of the theme 'Sensitive Attunement' (SA) gave rise to a growing awareness of elements that contribute to the PPS through observing contradictions and consequences, the challenge to patterns of response and the recognition of blocks to change. Sensitive attunement is therefore shown to facilitate Theme 8 'Behavioural Interventions and Responses' that acts as a bridge between brief psychodynamic and cognitive behavioural approaches to PPS (Table xiii).

It is also noteworthy, that the Common Factors literature (1.4.3.), expresses that the therapy's outcome is also dependent on the individual's readiness to engage. This is in part illustrated above in relation to behavioural interventions. However, if the individual appears not to engage in behavioural techniques, it is used in my own practice to direct a further exploration and adaptation between the therapist and patient to find alternative paths towards reaching their goals.

Consequently, we see that behavioural interventions can take a number of forms during the therapy intervention of this realist evaluation according to the presenting need:

- Checking medications for side-effects, taking medications correctly, revisiting GP for any changes
- Developing touch without fear of failure –Sensate Focus (Masters and Johnson)
- Progressive muscle relaxation
- Controlled diaphragmatic breathing

- Writing (not sending) difficult letters
- Challenging thoughts
- Developing choices and following through
- Mechanical assistance to maintain erection (Vacuum pump)
- Developing control over ejaculation time (delaying techniques)

When indicated, these interventions are offered as a choice: explaining purpose, checking what might get in the way, asking if the intervention is 'doable' for the individual or couple, thus enabling as much space for honest feedback as possible. In these four cases there were a number of behavioural interventions, which were used by patient and therapist although not all of the interventions above were found represented.

Theme 9: Developing Experiential Change

The interrelatedness of the themes of engagement were noted again when going on to distil the content within theme 9, 'Developing Experiential Change' Table 7.xiv). The distilled content of themes 1-8 above appear to result in an experiential change found here. Additionally, the value of personal goal setting with the therapist and regular evaluation of progress are observed here, both making change more readily appreciated and leading the individual to a conscious awareness of what works for them towards desired change. Moreover, one could also suggest from the data analysis, that the evidence here also facilitates an appreciation of what might be blocking change.

Theme 10: Checking for Intervention Acceptability

The positive impact of the change that is experienced during therapy is shown to be beneficial and is reflected in the relationship with current partners. This apparently results in a closer emotional connection. The final theme, 'Checking for intervention acceptability' (Table 7. xv) is in alignment with outcome researcher Lambert's findings (Lambert et al., 2001) based on the ongoing feedback into the therapy sessions of routine measures of change. In the study, the process of welcoming patient views

of the therapy is illustrated. What is important to the individual is shown in this analysis as the individual is given the freedom to express negative as well as positive views.

7.6.2. Summary of the distillation of themes

This section is a summation of contents of the distilled key themes and their contents as a higher abstraction (Tables 7. vi to 7. xv). This provides a systematically developed, comprehensive underpinning for a matrix of cross-modality modes of therapeutic engagement with persistent unresolved symptoms.

Table 7. vi) Higher abstraction of content: Therapeutic Alliance

1. Therapeutic Alliance:				
Generating hope	Exploring in safety	Giving personal value	Encouraging	Non-judgemental talking through
Giving & getting information	Timing & spacing of appointments	Obtaining brief medical & social history	Explaining the purpose and impact of emotion on the body	Making links between life events and physical function
Invitation to expand on story	Encouragement to tell their story	Following through session by session	Exploring goals	Exploring future needs
Joint enterprise	Co-equals	Checking if OK to continue	Checking back	Offering control over ending

Table 7.vii) Exploring the nature of PPS and initial goals for therapy

2. Nature of PPS & initial goals:	Case TN: Primary *RE	Case TG: Primary anorgasmia	Case SQ: Primary RE	Case BX: Primary **ED
Predisposing factors	CSA*** as a teenager	Childhood emotional and physical abuse by father continuing into adulthood	Felt sexual rejection as an adult	Childhood sudden loss of father, mother felt as emotionally invasive
Precipitating factors (to seeking help)	Flashbacks triggered by recent event	Probing of recent partner	New to dating after divorce	Recent life-threatening conditions
Perpetuating factors	Not telling, sense of shame, protecting self/other	Covering up, not telling, protecting self/others	Not telling, keeping busy, avoiding, protecting self	Not talking, covering up, protecting self/others
Nature of PPS complexity	Secondary erectile dysfunction (ED), loss of orgasmic feeling	Choosing unsatisfactory partners, sudden loss of feeling	Secondary ED, loss of arousal and feeling	Loss of connection between thoughts and arousal, loss of sexual confidence
Linked emotion	Frustration, despair, cut off	Involuntary loss of feeling, despair at injustice	Anxiety	Involuntary loss of feeling, frustration, anxiety
Initial goals	Greater satisfaction through improved function	Greater satisfaction through relationships	Greater satisfaction through improved function	Address anxiety to improve function

*Rapid Ejaculation (RE); **Erectile Dysfunction (ED) (seeTable 5.i); ***Child sexual Abuse (CSA)

Table 7.viii) Therapist Reflexivity

3.Therapist reflexivity:				
Defending and protecting	Not talking	Involuntary shut-down	Important to convey wellbeing to others	Loss of feeling

Table 7. ix) Use of symbol and metaphor

4. Use of symbol and metaphor			
Therapist initiating joint expansion of meaning	Pt. enabling expansion of meaning for therapist	Used to challenge and to precipitate action	Potential for returning to metaphor

Table 7. x) Sensitive Attunement

5. Sensitive attunement				
Reflexive interpretation- use of therapist self	Acknowledging pain and distress	Accepting the subjective view, use of participant's own words	Looking at wider patterns of response to life situations	Linking the wider patterns to the sexual PPS

Table 7. xi) Facilitating expression of emotion-renamed as 'Validating emotion'.

6. Validating emotion			
Clarifying and validating present feeling	Exploring past feeling	Finding internal conflict	Acknowledging previously unacceptable feeling or fact

Table 7. xii) Developing cognition in relation to emotion and the PPS

7. Developing cognition in relation to emotion and the PPS			
Making conscious through acknowledging & accepting emotion, through information sharing	Developing awareness	Tracking back through past experience	Wider life examples found as parallels to the PPS

Table 7. xiii) Behavioural Interventions and Responses,

facilitated by the content of the theme, Sensitive Attunement and by patient choice

8. Behavioural interventions and responses				
Making sense of elements possibly contributing to PPS		Recognising contradictions & consequences	Challenge to patterns of response	Recognising blocks to change
Patient facilitation of behavioural changes	Medicines with side-effects	Medications for physical dysfunction (PSS)	Follow-through & seeing results	Addressing blocks to facilitate progress

Table 7. xiv) Developing Experiential Change

9. Developing experiential change			
Facilitating cycles of self-awareness:	Developing confidence through goal assessment reviews	Changes in ways of doing through goal focus	Growth in self-awareness

Table 7. xv) Checking for acceptability of the intervention

10. Checking for acceptability of the intervention			
Asking/observing	Changing perspectives	Validating negative/positive feelings	Reviewing/Celebrating

7.6. Summary

In this ri-RSE analytic process, the developed cross-modality theoretical analytic framework underwent enhancement by an open coding process using sample therapy transcripts. By the abduction of the therapy transcripts (n=23) against this T-E theoretically and empirically devised analytic framework, the developed ten modes of engagement and their content, illustrated by verbatim samples, begins to reveal how and by what means the predisposing, precipitating and perpetuating factors of the main PPS were so readily accessed through the patient and therapist engagement over the first two therapy sessions. This process shall be illustrated as a realist CMO equation in Chapter 8. Moreover, the abductive data analysis of themes and the reflexive higher abstraction of content has laid a firm foundation for a cross-modality matrix of cyclical phases of engagement with persistent physical symptoms, facilitating the latter objectives for Aim 3 of the evaluation (Chapter 1.1).

This analytic stage four of the realist evaluation revealed that the themes of engagement 'Sensitive Attunement and 'Validation of Emotion' were integral to facilitating 'Cognition' and 'Behavioural Interventions'. Through observation and reflection on the data analysed within each case, this began to be understood. It was found that rather than individuals having 'irrational beliefs' (Ellis, 1977), the emotion, thoughts and feelings linked to the participant PPS was found signalling healthy responses to past danger and the consequent continued alertness to self-protection and the protection of others. These 'dysfunctional thoughts' (Shaw, 1999) appeared to be roundly embraced within the context of 'Sensitive Attunement' and 'Validation of Emotion' which facilitated 'Developing Cognition' and 'Behavioural Interventions'.

The role of the reflexive-insider therapist-evaluator has also highlighted by structured reflexive memos, the decision-making process that was

adopted during the evaluation journey, shown previously as underexamined (Bower and Gilbody, 2010). A higher reflexivity on the progress and direction of the therapy in Chapter 8 was also thus prompted, using Analytic Stages 5 and 6.

This last analytic phase reveals how the reflexive insider view of the T-E in and on the therapy process makes transparent the ways in which the participant and therapist are, over time, quietly dismantling the precipitating and perpetuating mechanisms of PPS. The ordinal process and outcome measures for each depth case and examined across cases in Chapter 8 provide a source of comparison to the qualitative process and outcome findings.

Chapter 8: Further Development of the Findings

8.1. Introduction and aims

The reflexive function during the analytic process (Chapter 7) reveals how decisions were made for study evaluation and the direction taken in developing the analysis of the qualitative data. The layers of reflexivity have brought a depth of focus on how patient and therapist relate to the PPS presented during therapy. It is noteworthy that within the realist evaluation paradigm, data is not only generated by, but is analysed by multiple means (Pawson and Tilley, 2004).

In this chapter, the qualitative analytic findings of Chapter 7 are developed further, through Analytic Stages 5 and 6 (Chapter 5.11.). The stages meet the final objective of Aim 3 of the evaluation (1.1.) to critically and reflexively develop clinical guidance and realist tools for effective engagement with PPS. A summary of reflexive observations over the data sets shall show the early discovery of predisposing, precipitating and perpetuating factors of the PPS (Table 8.i). This is followed by the developed matrix of cross-therapy modality PPS engagement (Table 8.ii). Moreover, the display of the concurrently written reflexive memos of the four selected cases of therapy, session by session are analysed further by the higher reflexive responses of the therapist. These observations by this means, are unique and generate the ability to observe common PPS disabling features of the engagement within and across the cases over time in therapy. This is rare material excluded from randomised controlled and from controlled before and after research studies (Leichsenring, 2005, APA, 2006). It cannot be objectively evaluated but it is used here to broaden the context, in which the reader can witness the process of engagement, showing real-life complexity and PPS change. The cross-

modality theoretical principles of engagement are drawn together and by reflexive distillation developed into simple representations, which can be useful for raising clinical awareness of common perpetuating factors and how these might be disabled. To complete the examination of 'how and to what effect the patient and therapist engage with PPS', analytic Stage 6 integrates the qualitative, quantitative and reflexive findings with cross case comparisons.

8.2. Early discovery of Predisposing, Precipitating, and Perpetuating (PPP) factors

On looking across the case transcripts during the earlier thematic analysis of engagement, the T-E observed that a combination of types of intervention were found to facilitate the discovery of precipitating, predisposing and perpetuating factors (PPP) for the PPS over the first two therapy sessions. These were formulated into a realist Context + Mechanism = Outcome 'CMO' structure, developed by Pawson and Tilley (1997) (Chapter 2.4.1.). This conveys the common processes that are found within the data leading to early PPP recognition (Table 8.i).

Table 8.i) Discovering Predisposing, Precipitating and Perpetuating factors

Context PLUS	Mechanism of engagement PLUS	Cycle of continuing engagement =	Outcome finding
Open invitation to engage with PPS	Invitation to expand on their own story	Taking the patient back again to when the PPS started	Precipitating factors
Taking a brief medical and social history back to early life: noting challenges	Eliciting past experience of PPS	Reflecting back the therapist (emotional and cognitive) response to what is said	Predisposing factors
Taking a brief medical and social history back to early life: noting challenges	Exploring impact of the PPS on self and relationships	Exploring desired change. Use of shared reflexivity to guide goal development	Perpetuating factors

The unique underlying PPP factors were found, over two 50-minute therapy appointments, discovered within and through the therapy relationship. Also, the awareness of the individual's personal context is developed organically through the types of exploratory engagement. This mutual, non-judgemental appreciation of context becomes foundational to the development of personal goals. These are explored in the reflexive memos of section 8.4. and later by the quantitative comparison with goal attainment.

8.3. Defining and developing a matrix of engagement

The process of analytic abduction as shown in Chapter 7, engaged in the tight and evolving revision of themes and their content. The final tables (7.6.2) reflect the higher abstraction of the content of the 10 themes. Here, these tables are merged and the superordinate content of the themes are drawn together to remove any reference to the individual cases. This process reveals how the preliminary cross-modality matrix of engagement (in landscape format Table 8.ii) becomes a Guiding Matrix of

Engagement with PPS. The content of the reflexive memos of therapy process above, were reflected within the principles of the framework.

Table 8.ii) Guiding Matrix of Cross-Modality Engagement with PPS

Engaging the Therapeutic Alliance	Generating hope	Giving and getting information	Invitation to expand on story	Developing the patient-therapist partnership (Joint enterprise)	
Exploring the nature of PPS & initial goals	Scanning for potential predisposing factors (P)	Discovering precipitating factors (P) (what brought you here/how did it start?)	Developing awareness of perpetuating factors (P) (what blocks recovery?	Understanding the detailed nature of the PPS (how and when does it occur?)	Valuing linked emotion (does the PPS still have a purpose?)
Therapist reflexivity (noting the following)	Loss of feeling	Presenting as being well in all other areas	Involuntary shut-down	Defending and protecting	Not talking/not telling
Using symbol and metaphor	Therapist initiating joint expansion of meaning	Embracing individual's expansion of meaning	Using to challenge	Potential to return for expansion of meaning	
Sensitive attunement	Acknowledging pain and distress	Accepting the subjective view, use of person's own words	Looking at wider patterns of response	Linking the wider patterns to the sexual PPS	Using therapist self to validate experiences
Validating emotion	Clarifying and validating present feeling	Exploring past feeling & previously unacceptable feeling or fact	Engaging reflexively with any internal conflict discovered		
Developing cognition in relation to emotion and the PPS	Acknowledging & accepting emotion, through information sharing	Developing awareness of self and others in relation to the PPS	Listening to past experience	Observing responses to wider life examples – finding the core elements	
Behavioural interventions and responses	Agreeing PPP factors that may contribute to their PPS: match interventions	Recognising contradictions & consequences relating to what is said and what is done	Challenging patterns of response	Recognising blocks to change	Valuing readiness or non-engagement with behavioural tasks
Developing experiential change	Facilitating cycles of self-awareness	Individual and Therapist making changes in ways of doing through goal focus	Developing confidence through goal assessment reviews	Validating what works	Finding out with the Pt. what they need next
Checking acceptability of the intervention	Talking/asking	Acknowledging personal perspectives, respecting needs for further change	Giving non-judgemental space for the expression of negative and positive response	Reviewing focus. Celebrating 'good enough' change	Agreeing how remaining work will be done

8.4. Analytic Stage 5: Process of dynamic reflexivity

During a therapy, the reflexive nature of the therapist enables deeper insight into what is happening in the therapy relationship and how this informs and impacts the direction of the therapy. This dynamic reflexive process provides a higher level of analysis on the therapy-content examined here. The act of a higher reflexive analysis on the direction of therapy generates a question, 'What mechanisms of PPS have been disabled through this engagement (if at all) and how?' This was answered by the insider T-E, stepping back and looking in and over the reflexive data generated immediately after each therapy session from the privileged position of being there.

The therapy process notes were taken from part I of parts I-III of the therapist accounts, that were completed immediately after each therapy session (see Appendix 5, CSEP II Experiential Therapy Session Form, Elliott, 2002). Additionally, this included a check on external events that contributed to therapy outcome. The therapy process was witnessed as a cyclical process of change over time, which was supported by personal 'readiness' and situational circumstances. The reflexive format: What? So what? Now what? was used at the time to enhance the concurrent session notes, forming the reflexive cycle. Thus a focus on remaining attentive to the individual's and the therapist's (the T-E) subjective experience in and shortly after the engagement was foundational to facilitate analytic Stage 5. Moreover, at the time, the simple capture of reflexive thought and feeling also facilitated subsequent case reviews through monthly clinical supervision. In practice, Freshwater and Rolfe's (2001) Type II theoretical and cultural perspectives can be considered in the clinical supervision setting, but are not included here.

Additionally, the four depth cases 1-4 have the following research identifiers: SQ, TG, TN and BX. See Table 7.i) for the four participants'

general demographics. For ensuring ethics compliance in patient confidentiality, T-E remains the only individual who holds the key to the participants' true identity. This key shall be destroyed once the academic award is achieved. Each participant reflection is given by session to show the direction of therapy as it developed over time.

The reflexive memo tables shall cover all four participant full therapies. The simple reflexive construct: What? So what? Now what? provides table headings and these are populated session by session with the concurrent reflections on therapy process. In this account the generic term persistent physical symptom (PPS) is generally kept to allow the reader to see that the principles or patterns of addressing the predisposing, precipitating and perpetuating mechanisms (PPP) of persistent sexual symptoms (PSS) revealed here, have the potential to be applied to any PPS. Verbatim quotes are all shown in italic script. Also, retrospective, reflexive observations addressing the question of what has disabled the mechanisms of delay in PPS recovery and on the enabling resources required for the relief of the presenting PPS, are identified.

8.4.1. Participant SQ

Participant SQ, an Asian male aged 26-25, registered into therapy with deep concern at his increasing sexual dysfunction on the resumption of dating after divorce. SQ was seen on three occasions over a period of five months. The following landscape format illustrates the first reflections in and on session one (Table 8.iii) to session three, which constituted SQ's whole therapy.

Table 8.iii) Participant SQ(1): Dynamic reflexive memo

Participant ID & Session no. ( )	**What?**	**So what?**	**Now what?**
SQ (1) Primary Rapid Ejaculation (RE), plus Secondary Erectile Dysfunction (ED) and loss of arousal	He says, 'I am strong'	Is there fear of being labelled 'weak' in using a psychological route for exploring why there is a problem?	Keep alert as to how this itself might impact sexual function
	Medication: i) O… for gastric reflux ii) *PDE5i not working –tries double dose which is a bit better, not great	i) Occasional side effect of O… is ED Gastric reflux in itself can be identified as a PPS ii) may indicate that the ED has an organic cause	i) Advise to see GP if an alternative is possible; explore if this gastric reflux influenced by stress ii) Despite investigation, GP has not been able to detect organic cause to date
	i) Wanting to hide the physical 'dysfunction', not ready to tell new partner ii) Previous marriage: 'Perfect' relationship apart from the sex, but then rejection, shock, humiliation by betrayal	i) Self and ex wife at the time unable to talk, have not talked since about the subject ii) finding out why they had a problem with intimacy seems to have started to make sense to him. Linked shame had been minimised, covered over	i) ED may also be linked with this unresolved hurt, exposure, shame. Plan: to explore ii) Today we acknowledge his busyness as a means of distracting from past shock and shame. He is calm, feels he has moved on

*Phosphodiesterase Type 5 inhibitor (PDE5i)

Table 8.iii) Participant SQ(2)

Participant ID & Session no. ( )	**What?**	**So what?**	**Now what?**
SQ (2)	SQ has begun to take control over his physical circumstances, reducing medications in consultation with GP	ED not mentioned as a problem today, has managed x1 without PDE5i; follow his lead-asking for help to control his RE	Facilitate SQ to find ejaculatory control by behavioural exercise

Table 8.iii) Participant SQ(3)

Participant ID & Session no. ( )	**What?**	**So what?**	**Now what?**
SQ (3)	SQ no longer needing medication	What-has made the difference?	Feels happier, more secure in the relationship in contrast to first marriage. He has become engaged.
	Still not told current partner he is attending therapy	I have concern about this. But his confidence has grown, the relationship secured, function restored *SQ(3)…' , it just feels much more balanced and normal.'*	SQ can see the previous patterns of response and reasons for this. Feeling confident in himself and his partner, less fear of rejection. Sexual experience is much improved.
SQ End of therapy: Final reflection by T-E	Long spaces between appointments, the work felt mostly behavioural	Taken to case supervision: Hidden events have been shared and difficult feelings acknowledged Goals have been achieved as therapist follows his lead	Learning: T-E finding evidence that intensive short-term therapy does not always have to involve high emotional expression but a validation of past negative feeling seems to be enough

8.4.1.i) Participant SQ: Disabling PPP mechanisms

Participant SQ: In relation to PPS, with the help of therapy, what mechanism had been disabled and how? In the first therapy session, past shock and shame which had been covered over, protecting others from knowing, by busy activity, projecting, 'I am strong', had been acknowledged. It was subsequently observed that SQ's sexual function was reported as improving after this. SQ's hidden stress had become known and shared within the therapy relationship. However, this evaluation material was not shared with his new partner. The couple secured their relationship. SQ no longer showed signs of pre-occupation with sexual performance and fear of failure; his previous anxious need for medication to support erections had gone. The ability then to commit fully to a new partner was reported and observed to make all the difference to his sense of wellbeing by SQ comment, 'it just feels more balanced and normal'. Also, the suggestion of an alternative medication for gastric reflux (which can be a stress–related symptom and ED is also known as a side-effect of the medication he was using) was not required as his symptoms had abated.

8.4.2. Participant TG

Participant TG is a white European female aged between 46-55 with a 31-45year history of anorgasmia in relationships and minimal feeling on intimate self-stimulation (masturbation). On entering the program, TG engaged with a full first therapy contract of assessment plus six follow-up sessions, totalling a 7-session therapy over eight months. In the service, TG and the therapist are found in the complexity of the therapy process illustrated at session 1. (Due to word count constraints the remaining dynamic reflections on sessions 2-7 (Table 8.iv) are found at Appendix 19.).

Table 8.iv) Participant TG(1): Dynamic reflexive memos

Participant ID & session no. ( )	**What?**	**So what?**	**Now what?**
TG (1) Anorgasmia	Why is TG so distressed at the idea of returning to repeating the patterns of her early adult life of 'walking away' from relationships	This distress may be a key to her PPS.	Needs further exploration.
	TG is showing signs of ambivalence about attending the therapy sessions	What is this ambivalence about for TG? Is there a lead, a clue in the statement: '*If I were a man I would have come for help years ago. I am a woman, I put up with this.'*	Why is she making this contrast between men getting what they need, demanding it and women keeping quiet, putting up with it. Is this a glimpse of predisposing factor? Needs further exploration.
	TG chooses the metaphor of colour to describe her relationships: Sex is magnolia or grey, Dad is grey. Children are peach.	Magnolia to orange is image of preferred outcome	Use of metaphor gets us nearer to the heart of the matter? Something to do with father and sex?
	When TG shows emotional upset, she feels embarrassed, ashamed here.	In the moment, I feel taken aback: when given careful attention, TG feels worse.	Where does this originate from? Does this offer a live link within the therapy to her PPS and reactions to others/to intimacy?

8.4.2.i) Participant TG: Disabling PPP mechanisms

As a final reflection two months after therapy end, as seen in the remaining Tables 8.iv), session 7, Appendix 19, I noted my own ambivalence as to whether TG could, given her long history, allow herself to come back into therapy if she needed it. After cycles of gentle exploration in therapy TG was found to have been protecting her parents and herself from acknowledging the profound impact of the emotional abuse she had suffered both in child and adulthood. TG revealed her gargantuan efforts to seek their approval, *'I will go all out to be your best girl'*, (Session 2) but the critical response to all these attempts made her bewildered and unsure of her own value. Moreover, her bewilderment continued into her adult intimate life, *'I just don't know how to deal with injustice that I feel'* (Session 4). She expressed a pattern of walking away from relationships despite sexual attraction, before they left her. TG could neither 'let go' and be orgasmic with any, nor with herself. She could not make sense of these patterns. Nevertheless, in the therapy relationship, unacceptable aspects of her experiences in childhood and in adult intimate relationships were shared, her survival attempts valued and this facilitated the expression of previously hidden, unsafe powerful negative emotions and to make sense of her patterns of response, *'…so when it comes to a sexual thing it is actually resentment that's there that I hold back. I don't give myself fully - I'm not only denying myself, I'm also denying them.'* (Session 6). Moreover, self-judgement had been high, 'I know the 1st 3 or 4 times I hated coming and not myself because I felt like I was coming because I was a failure. I just felt like I shouldn't be doing this, but I don't feel like that now feel more sort of like I'm just doing something that needs to be done...' (Session 6). The non-judgemental engagement in therapy appears to have allowed TG to begin to make a new assessment of herself and to find a greater equilibrium and freedom to acknowledge and care for her own needs in therapy, *'…it's just something that's okay.'* (Session 6).

As I reviewed her case against the matrix of cross-modality engagement seen earlier (Table 8.ii), I was once again challenged. The matrix showed that the intervention was found to engage in psychodynamic principles and behavioural techniques both contributing to change over time. By the end of a first therapy contract TG was beginning to find a freedom to make new choices and her wellbeing improved. She made a successful job application. TG chose to engage more openly with herself and with others and to see less of her father. However, it was possible for TG to express, that waves of self-criticism and mistrust at times remain overwhelming (Session 7). Although TG had been able to avoid the next 'toxic' relationship, she had not yet had the opportunity to find out whether orgasm is possible. The door is open for TG to return to continue her 'work in progress' should she need it for herself or when she is in a new relationship.

8.4.3. Participant TN

Participant TN is a white male between the ages of 26-35. He came into therapy to address secondary erectile difficulties that he had experienced for a period of 1-4 years. TN had a total of six therapy sessions over eight months. He presented as pragmatic individual in relation to a manipulative relationship with an older person in his teenage years and wanted improved sexual function as soon as possible. Sessions 1, 2 & 6 are tabled following (Tables 8.v) with the remainder found at Appendix 19.

Table 8.v) Participant TN(1): Dynamic reflexive memos

Pt. ID & session no. ( )	**What?**	**So what?**	**Now what?**
TN (1) Primary RE, Secondary ED, loss of feeling	Is the primary Rapid Ejaculation(RE) and secondary ED linked to Childhood (teenage) Sexual Abuse (CSA)?	Find out: always had RE, but ED with loss of sexual pleasure has occurred only since CSA court case	I note in this session the need to protect others from knowing about the CSA-family and partner. It is minimised.
	TN appears self-contained, he compartmentalises past experience and protects others from being disturbed	This left him isolated with what had happened in childhood and by report seems that this may have resulted in low level low mood on and off over years, not knowing why…	A TV recent programme on CSA triggered poor sleep. The subsequent preparation for court action prior to coming for help meant that TN had already disclosed the facts of what had happened. Shortly before this disclosure he developed ED.
	General health: long term condition, well-controlled with preventative medication	Did the first medical episode in late teens impact on developing the primary RE? On reflection the RE does not seem relevant to the work in hand at this stage	Ensure exclusion of medical factors, referral back to GP if needed: no indicators to do so at the moment
	What is TN's relationship to the main PPS (i.e. ED)?	It makes him feel 'rubbish' that he cannot give his partner what she deserves	TN reports he is getting less pleasure himself and wants this to change- he is frustrated and sad
	Other PPS?	Upper back pain and knee pain-started over this same period	Are the PPS all interconnected?

Table 8.v) Participant TN(2)

Participant ID & session no. ( )	**What?**	**So what?**	**Now what?**
TN (2)	Not easy for TN to connect with others; needs to protect others (parents and wife)	Is it possible to ask the unspeakable question: Was there anything TN got out of the early sexual encounters, however unwelcome? He says there was excitement with the novelty- but it was with a man and that felt wrong for him	What is TN left carrying from this early adolescent experience?
	TN compartmentalises the CSA, as if it wasn't impacting the rest of his life then or now	Where is his feeling response to the CSA?	Be mindful of this
	Has CSA impacted on TN's sexuality in any way?	He has fears of being gay. TG continues to show no emotion about the CSA	Does any of this (lack of emotion) impact on his current sexual PPS?
	The CSA bothers his partner not him, even so, he tries to protect her from the detail. He reports she is angry	Is she expressing the feeling on his behalf? It seems to be affecting her sense of well-being and security-she feels betrayed and angry at his secrecy and the declining quality of their intimacy	Does this add to the mix relating to the ED? A pressure to perform in the face of his partner's disappointment with the loss of openness? Can he talk more openly with her?

Table 8.v) Participant TN(6)

Participant ID & session no. ( )	**What?**	**So what?**	**Now what?**
TN (6)	The couple have now talked about the CSA and his partner's fears relating to risk to their children. He listened and did not turn away as he might previously have done to avoid painful argument. Reporting improvements in all areas	There is evidence now that the couple can hear each other, address difficult feelings and accept them Partner no longer angry, but pleased that he has followed through by getting help Reporting restored sexual function: RE, ED and intimate satisfaction much improved	Learning: My concern over lack of expression of emotion in particular ways and over issues of current and future risk led to prioritising theory of risk over keeping attuned to TN in the here and now. Supervision: It remains crucial nevertheless, to consider serious risk to others. An after the event exploration of therapist 'in-session' feeling allowed an appreciation of the work TN and his wife had undertaken, sharing what had previously been unspeakable... My review of notes showed me that TN did feel anger (mainly at himself) and longed for help as a teenager. This was overridden by the need to protect parents from the impact of the CSA in their community and a felt sense of his own complicity in what was happening.

8.4.3.i) Participant TN: Disabling PPP mechanisms

With respect to this couple in therapy, my end of therapy reflection notes that despite my pre-occupation with the felt need to facilitate an expression of anger, over TN's time in therapy the couple had concurrently been enabled to listen to each others' deep fears and concerns. Following this, TN showed an all round improvement in relationship and sexual satisfaction. Moreover, TN's primary RE condition was also helped by the use of a concurrent behavioural exercise that was suggested at an early stage in the therapy.

I note again that the ''not-telling' or 'not-talking' is to protect; here it is used to protect others from collateral harm, but appears to result in a PPS perpetuating factor creating greater complexity for TN's intimate relationship in the here and now. The therapy relationship allowed the 'unspeakable' to be expressed, which seems to have created enough validation of the reality of TN's experiences to allow himself in turn to listen to the unacceptable accusations of his wife without self-protecting avoidance. Prior to therapy, this unspoken issue had been brought back to life by watching a TV documentary on CSA resulting in persistent poor sleep and episodes of low mood, followed by ED and loss of sexual feeling. This exploratory engagement with the sexual PPS between patient and therapist within the context of TN's story appeared to disable the identified perpetuating factors: his need to protect family and community, by not telling or telling very little of what had happened. This factor had resulted in a witnessed disconnection within his intimate relationship and sexual function. At the same time the impact of a predisposition for PPS, childhood sexual abuse (CSA), appears reduced during the therapy engagement by acknowledging and validating the mixed emotions. Moreover, TN reported that the behavioural technique to gain ejaculatory control helped with his primary RE. By the end of therapy TN also reported that the upper back and knee pain had gone and sexual

function and emotional intimacy had been restored. The therapy engagement within this therapy process, with the focus on the presenting PPS, appears to have substantially relieved all PPS. Both TN and his partner felt the final solution to their painful disengagement came through TN's engagement with the therapy process. They were never seen as a couple.

8.4.4. Participant BX

The fourth participant BX, is a white male between the ages of 46-55. BX was referred to the PSCS by his GP through Hospital Medical Consultant recommendation. The sexual dysfunction was picked up through the treatment process of a more recent life-threatening illness. His partner attended the first session to let the therapist know the details in case BX did not recall them. BX had a history of primary ED experienced over a period of between 21-30 years with 4-5 month complete shut-down of sexual activity every year since the start of the relationship. As I meet BX and his partner, I experienced profound and immediate physical and emotional responses to their account of events. Sessions 2 and 3 are presented following (Table 8.vi). Due to word count restrictions the remaining reflexive concurrent tables for BX, (Table 8.vi, Sessions 1, 4, 5, 6 & 7) are found at Appendix 19.

Table 8.vi) Participant BX(2): Dynamic reflexive memos

Pt. ID and Session no.	**What?**	**So what?**	**Now what?**
BX (2) 1:1	I have a feeling of shock in my own body as therapist as BX parent's sudden unexpected death is yesterday, as if blood is draining from my legs. *Th: how has it been going back to talk about [this] sudden-death today?* *Pt: I've talked about it many many times to many people, the feeling is always the same, incredible sadness,… As I said it just never seems, it doesn't seem to diminish.…* (big sigh)	I have the same feeling in me when B describes loss of erection: a sudden, catastrophic loss.	Is this a kind of PTSD now linked to sexual function? I am struggling to reflect this back- there is something there that is hard to name. Supervision: There is a fear of death in me, perception of fragility, some sort of fear of confrontation within this session within myself, I have a fear of becoming the third woman, uncomfortably invasive. Plan: Look at the parental roles and find out where is BX in all this.

Table 8.vi) Participant BX(3)

Participant ID & session no. ( )	**What**	**So what?**	**Now what?**
BX (3) 1:1	BX appears caught between 2 women that he must take care of. *Pt:...they are completely polar opposites but obviously because of who they are obviously it hasn't been possible but to sort of say that directly to my mum would be I think fairly cruel to be quite honest as well.* *Th: why would it be cruel?* *Pt: Because I don't think she would be able to handle it* *...but obviously being on my partner's side as well because I know it's very difficult for her because they are completely chalk and cheese and so yea it's just a difficult it's a difficult position…*	BX is Intimating it is better to *'bumble along'* and not cause upset to either woman. He reflects, *Pt: Yeah not to lapse into the easy way of not, not being intimate because that's the easy thing to do* *Th: okay to avoid intimacy altogether?* *Pt: Yeah so so yeah …*	Is *'bumbling along'* to keep the peace, not expressing his own thoughts and feelings reflected in the lack of erections and periodic hibernation? I don't know. BX suggests it easier to avoid intimacy, go to a fall back position rather than risk upset of failure or not being good enough…? Reflect further: Is there potential to express his potency somehow? What is perpetuating the difficulty?

8.4.4.i) Participant BX: Disabling PPP mechanisms

In my latter last session reflections, I note that in one sense there is a feeling of hopelessness that nothing works, a resignation, in case of BX. Yet BX reports from his goal attainment much positive movement towards his goals for therapy (see later in this chapter).

It takes a deep and repeated cycle of reflexivity on the engagement in therapy, to make the connection between early life sudden loss, his dependency on his remaining parent's survival and his loss of sexual potency. Nevertheless, the repeated reflexivity cycle helps in appreciating why his potential as an adult, to challenge unacceptable aspects of that early and understandable relationship dependency continues into adulthood. There is a deep need to avoid potential harm or loss found through the reflexive process. This is, in some way, generated also in relation to his partner. BX too, finds an involuntary physical shut down and sexual disconnection from his partner to her great but usually unexpressed distress. However, she does not want to put him under pressure and so minimises her own sexual needs. BX does not want to give her more [back] pain. Foreplay has been regularly enjoyed over time in therapy and the erection, although now available to them both, remains fragile: as soon as BX is aware that his partner is in discomfort, it is lost. Is avoidance of this loss or harm potential BX's means of survival?

The couple have been able to engage in the exploration of the PPS, but I notice that BX is less practically engaged in moving forward. Therefore, at present the potential discovery of his natural physical function is not possible. BX continues to show a need to defend and protect his love for his mother and her love for him and to avoid facing potential loss of any kind, at all costs (see Session 5). However, the couple reported with pleasure that the usual several-month sexual shut down had not occurred whilst engaging in therapy. The emotional enormity of extra-therapy

events i.e. BX's medical condition, were at first minimised by the couple's account. In contrast, a deep relief was observed in receiving effective treatment uniting the couple in survival, even further.

8.4.4.ii) Participant BX: How far were the PPP mechanisms disabled?

During the therapy, the couple were able to express frustration and a degree of despair, both showed and recognised their own withdrawal from sex as a way of protecting the 'other'. The couple kept their emotional connection through mutual respect, deep friendship and hugs and kisses. However, these were essentially non-threatening, non-sexual acts. Also, behavioural interventions generated in other medical settings and through the therapy appeared blocked by the lack of time or feared pain responses. Nevertheless, the acknowledgement of fear of loss love in relation to his surviving parent was, on reflection, potentially supportive of BX's recovery from a previous paralysis to act on his own need for independence and adult intimacy. BX was set on addressing his mother in her naturalistic setting as and when a conflict showed itself in the future. BX expressed a wish to return to continue in therapy later in the year.

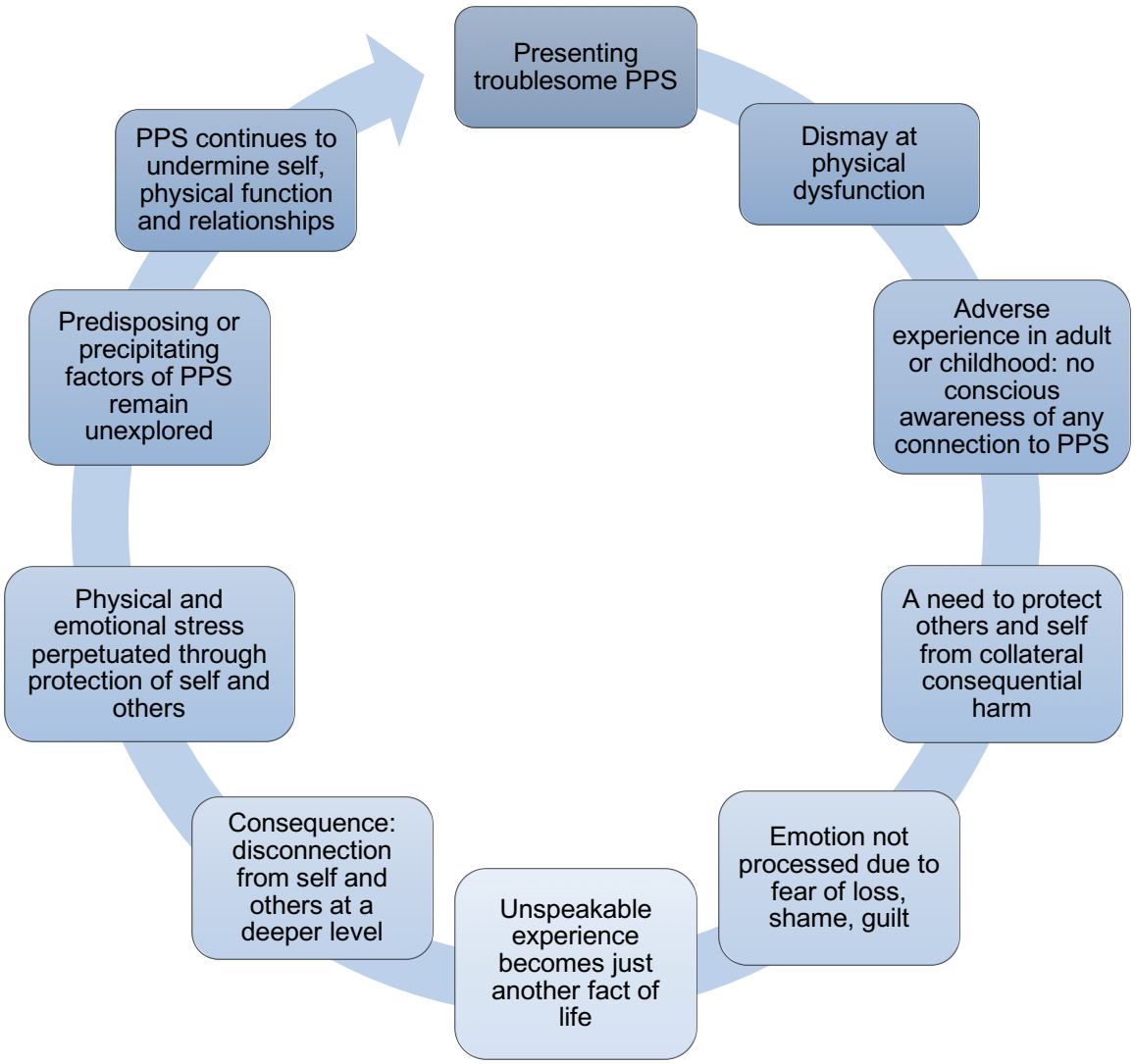
When I set the reflexive accounts of BX's therapy against the developed matrix of cross-modality engagement, I observed that once again my appreciation of the value of brief cognitive-behavioural techniques and brief psychodynamic principles combine to meet the needs of the individual. Although the benefits were not yet fully realised, the psychodynamic perspective helped me to maintain the hope of further change over time rather than to conclude that the couple could not be helped further. The reflexive material on BX's case also provided a further confirmation of the cross-modality themes of engagement (Table 8.ii).

At this stage of the evaluation analysis it becomes possible in the following section to distil the common features of engagement with PPS found across the cases.

8.5. Analytic Stage 6: Cross-case comparisons

Three of the four cases above, all selected by consecutive referral and meeting the inclusion criteria for the evaluation, gave indication of early life adversity. This has been already acknowledged in the research literature as a predisposing factor for PPS (Wilkinson, 2010). The exception was an adult experience of betrayal and rejection, also previously identified as a predisposing PPS factor (Wilhelmsen, 2000). In these cases, that are examined at depth, it is noted that each had some form of challenge with their sexual function from the outset of their sexual lives, but that this was not necessarily subjectively experienced negatively. Rather, all were hoping that sexual function would improve over time and through experience. Notably, it was found that recent life events precipitated or triggered all four into finding help to address secondary Persistent Sexual Symptoms (PSS) and relationship challenges that were not getting better over time.

Also for evaluation purposes, commonality and difference were checked. All four cases, although each very different, had a pattern of response, which appeared to perpetuate the impact of their predisposing factors for PPS which, until engaging with therapy, had caused a sense of frustration and dismay concerning the physical 'dysfunction'. These common factors are built into Fig. 8.1. Additionally, the guiding principles for patient and therapist who work together on PPS was developed through the findings from Stages 4 and 5 of the analytic process. The common factors found from the end of analytic Stage 4 were affirmed through Stage 5 reflexivity on each case and by across case observations.



F*ig. 8.1 Common patterns found perpetuating the predisposing and precipitating factors of PPS*

It was also observed that a disconnection from some aspect of previous experience seemed to play out in relationships and expressed through the physical 'dysfunction'. The on-going protection of self and others

appeared to perpetuate the impoverished sexual response cycle. Moreover, a worry about the dysfunction and fear of failure or let-down placed a further barrier to intimacy or ‘connection’ to the other.

The diagrammatic display of Fig. 8.1 allows a clearer view of how natural self-protecting mechanisms in response to predisposing factors for PPS discovered within the data (ie. some form of adversity) are addressed and disabled as the patient and therapist engage in developing and achieving personal goals for therapy.

8.6. Disabling the mechanisms of PPS perpetuation

The summary of a flexible cycle of a facilitatory engagement with PPS is illustrated (Fig.8.2). The cycle is distilled from the preliminary matrix of cross-modality engagement (Table 8.ii) and affirmed by the higher T-E reflexivity within and across the cases.

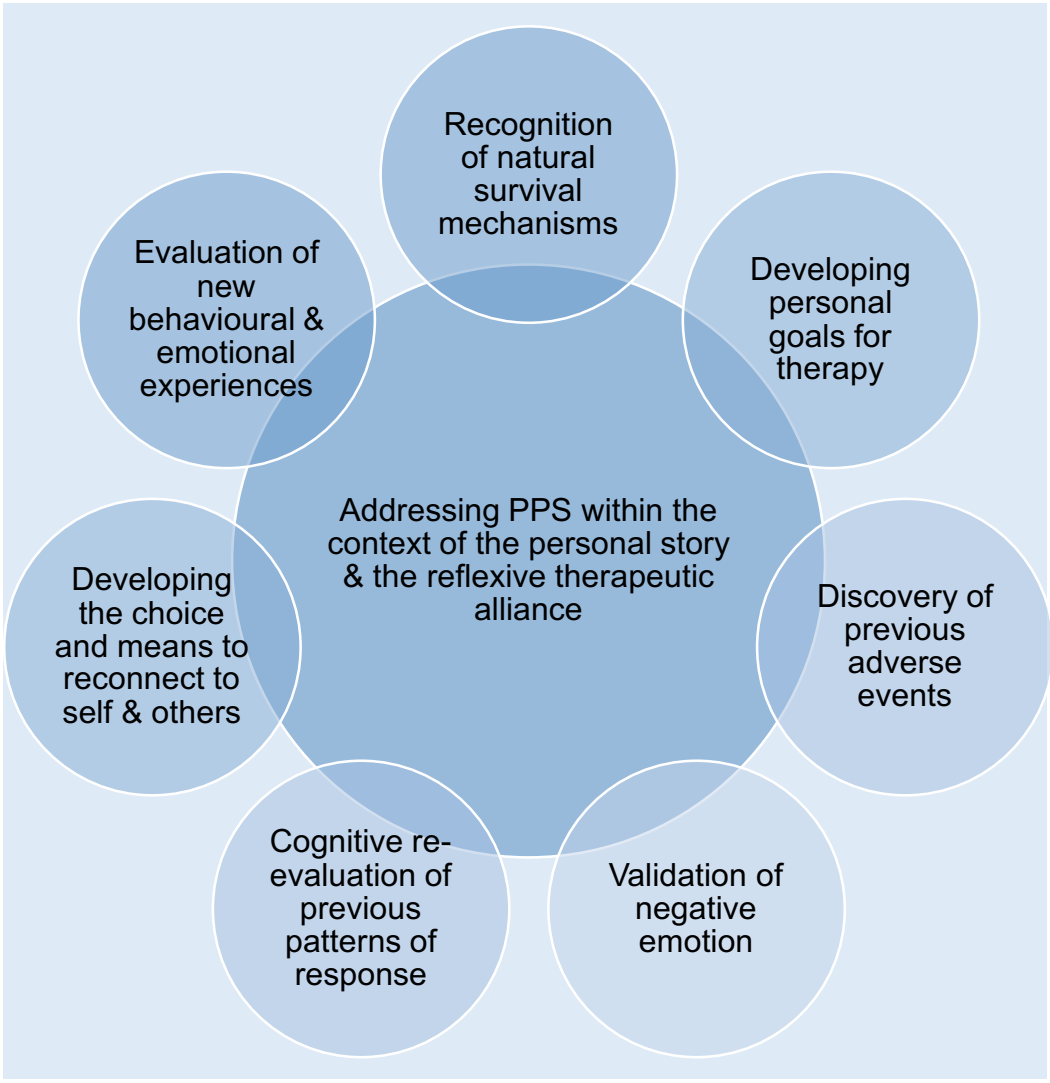


Fig. 8.2 A cycle of principles of engagement found disabling the PPP factors

The matrix of cross-modality engagement (Table 8.ii) illustrates, along with the higher reflexive process in and on the therapies, how these principles at Fig. 8.2 are enacted in practice by an iterative cyclical means. The figure shows how the reconnection to self and others is facilitated within the non-judgmental, reflexive therapeutic relationship. Also, although the figure implies a number of domains to be addressed, it is through the lived therapy process found in this evaluation using cross-modality principles of engagement, that leads to the dismantling of the power of the unique PPP factors. During the therapy, through brief history-taking and the creation of personal goals for therapy between individual and therapist acted as a

guide for the therapy process towards a patient-focused engagement with the PPS and to what was personally relevant. The progress towards achieving personal goals are quantitatively evaluated below by individual and across the individual participants in relationship to the qualitative analysis, telling a wider story.

8.7. Reflexivity on and across the types of data

8.7.1. Personal goals for therapy

The validated measures of well-being and somatic symptom severity scores provide context and measured outcomes for these four individual cases. The results of the Warwick and Edinburgh Mental Well-Being Scale measure (WEMWBS) are shown next to Somatic Symptom Severity Scale (PHQ-15) (Table 8.vii) over Time 1 (before the assessment), Time 2 (at the mid-way point) and Time 3. These two questionnaires were completed in privacy immediately before each of these appointments. The length of primary PPS symptom history is given in years and secondary PPS shown in brackets alongside, with the total number of therapy sessions and time in therapy.

Table 8.vii) Context: Well-being (WEMWBS) and Somatic Symptom Severity (PHQ-15) over time in therapy

Participant ID & Time point (1, 2, or 3)	Presenting PPS	Length of history in years & (secondary symptoms)	Total No. sessions by therapy end	Months in therapy	WEMWBS Score 14-70	PHQ-15 None 0-4; Mild 5-9 Mod 10-14; Severe 15+
TG/T1	Anorgasmia	21-35			49	2
TG/T2					36	7
TG/T3			7	7	52	2
SQ/T1	Primary RE, secondary ED, loss of arousal	6-10 (1-5)			60	4
SQ/T2			3	5	62	0
SQ/T3			-	-	-	-
BX/T1	Primary ED, with secondary low desire	21-35 (21-35)			54	4
BX/T2					57	2
BX/T3			7	9	59	3
TN/T1	Primary RE, secondary ED, loss of feeling	6-10 (1-5)			58	5
TN/T2					54	3
TN/T3			6	8	56	1

Of the four consecutively referred cases, the wellbeing score at outset, taken by the Warwick and Edinburgh Mental Well-Being Scale (WEMWBS), shows a mean of 55.25 (Standard Deviation, SD= 4.85), this is higher than the mean for the therapy caseload of those who completed therapy with scores available (1st April 2014 – 31st March 2015, (n=33) (Fig.6.7). The mean baseline wellbeing score of those who completed therapy was 44.125 (SD=11.25). It is noted here that these four consecutively referred cases with higher wellbeing scores registered either 'no somatisation' or 'mild somatisation' on the Patient Health Questionnaire Somatic Symptom Severity (PHQ-15). And yet their sexual PPS were found severely disruptive to and powerfully undermining of intimate relationships. None of the participants would have been accepted into high intensity therapy within IAPT Wellbeing services on this basis, at the time of referral (IAPT, 2014).

However, the PHQ-15 also did not pick up the severity of any of the participants' sexual difficulty at baseline. The question in the PHQ-15, 'During the last four weeks how much have you been bothered by pain or problems during sexual intercourse?' and the reply options: 'not bothered at all', 'bothered a little' or 'bothered a lot' did not adequately capture the stressful nature of this type of PPS. This suggests that the PHQ-15 needs further development to fully recognise the personal stress of persistent sexual symptoms.

At Time 2 the mean wellbeing score of the four cases was lower at 52.25 (SD=11.32) reflecting the pattern within the T-E therapy caseload as a whole who showed little improvement in well-being scores at Time 2 (Table 6.v). At Time 3, the wellbeing score for the four depth cases rises from baseline to a mean of 57.25 (SD=4.27) giving a change of 5 units over time in therapy. This compares to a change of 3.125 units across the n=33 of those who completed a full therapy contract within the caseload with scores available (Table 6.iv). This descriptive quantitative data will next be set alongside the measures of personal goal achievement.

8.7.2. Personal goal assessment

The personal goals for therapy were developed and identified between patient and therapist in the early phase of engagement. For this analysis, the goals of the four depth cases were grouped into six themes (see Appendix 14). These were checked for content by a senior healthcare researcher (EC):

1. Work on communication
2. Work on self
3. Regaining sexual desire
4. Developing sexual confidence
5. Improving sexual function
6. Greater sexual satisfaction

The personal goal attainment of the four cases is set within the context of the ordinal scores in wellbeing. Changes in Likert Scale ratings of goals of 1-7 (where 1= no change and 7= completely achieved) are tabulated by Time 1,2, and 3 and by cases TG, SQ, BX and TN (Appendix 14).

The Likert scale shows ordinal change and is by nature discreet to the individual respondent (Sullivan and Arlino, 2013). In this instance, for example, the two five point changes in goal achievement belonged to participant SQ who underwent the shortest therapy (3 sessions over 5 months) and had an adult rather than a childhood predisposing factor for his sexual PPS. SQ's wellbeing score had concurrently improved by 2 units 60-62 (range 14-70) and a four-unit somatic symptom score reduction by the end of therapy.

The summary results of the 7 point Likert scale of goal assessment can be interpreted in the light of the work of Jaeschke et al., (1989) and Juniper et al., (1994), referred to previously (Chapter 6.6): Likert point change 'minimal important difference' is suggested as close to 0.5; 1.0 point change indicative of 'moderate change' and more than 1.5 point change suggesting 'large change'. Using the Goal Assessment Form (Appendix

4) each individual could develop, with the therapist, up to five personal goals.

A summary of the results is shown

- All participants show 'large change' in Likert scoring greater than 1.5 points on all goals with one goal exception (TG, Goal 4)
- The one goal exception (TG, Goal 4) was scored at a difference of 1 Likert point, suggesting 'moderate change'

8.7.3. Contrasting goal attainment with WEMWBS and PHQ-15 scores

The large change across personal goal assessment found at 8.7.1. for all four participants does not appear to have any consistently reflected pattern within the measures selected for assessing wellbeing and somatic symptom severity.

Table 8.viii) Well-being and somatic symptom score change comparisons

Participant	WEMWBS Low to higher (14-70) pre-post	PHQ-15 None to severe (0-15+) pre-post	Background to PPS
TG	49-52	2-2	Early life emotional adversity
BX	54-59	4-3	Early life severe loss
SQ	60-62	4-0	Sexuality related trauma in adulthood
TN	58-56	5-1	CSA in mid-teens

The positive change in wellbeing for TG and BX by 3 and 5 points respectively in this analysis appeared greater than that for SQ and TN. However, the somatic symptom score for TG and BX showed less change over time in therapy and this was reflected in the clinical encounter. However, both TG and BX registered scores between 0-4, 'no somatisation' at the outset. The remaining two participants SQ and TN showed for wellbeing either a 2 point 'improvement' by increased score or a 2 point reduced score respectively with reduced somatic symptom

scores of 4 and 5 units respectively by the end of therapy. However, minimal or lack of wellbeing change recorded by the WEMWBS was not reflected in the clinical observation: Both SQ and TN communicated satisfaction and relief in the positive change in physical function and intimate relationships but this substantial relief of stress relating to the PPS. However, there was large change in PHQ-15 scores of 4 points each in symptom reduction, which was confirmed by their subjective accounts SQ (Tables 8.iii) and TN (Tables 8.v). Again, as above, here is evidence to argue that the PHQ-15 did not consistently pick up the stress of sexual symptoms due to its poor sexual question construct.

In trying to make sense of these differences in wellbeing and symptom severity scores it was noted that TG and BX had experienced profound, although very different early life adversities. Especially, in ongoing child to adulthood relationships that had severely undermined their self-confidence at the level of relationship intimacy. Much work was undertaken within the therapy to address the core patterns of response within relationships that had become so diminishing to their sexual function. Additionally, it was observed that changes were emerging through an enhanced understanding of self and reactions to circumstances. Both TG and BX were invited to engage again with therapy when they would feel that the time is right to secure further physical improvements. In contrast, SQ and TN conveyed little adversity within parent-child relationships, and were older at the time of their PPS-related triggers. When noting these wellbeing and somatic symptoms scores with lack of pattern against a remarkable personal goal achievement by Likert Scale (8.7.2), it was concluded that goal assessment appeared to represent more accurately the change experienced during therapy, as important to the individual.

8.8. Summary

This chapter has shown the further development of the qualitative evaluation through the reflexive function of Stage 5 of the analytic process. The higher reflexive analysis in and on the therapy process shows the development of a realist 'CMO' equation illustrating the means of early discovery of the predisposing, precipitating and perpetuating factors (PPP) of the PPS (Table 8.i). The discovery of these PPP factors during the early therapy process were subsequently shown to guide through the individual history, experience and social context towards the process of developing personal goals for therapy.

The further development of the Preliminary Cross-Modality Matrix of Engagement became a Generic Matrix of Engagement with the predisposing, precipitating and perpetuating factors of PPS (Table 8.ii). These derived theoretical and empirical principles of intervention-processes contribute to a realist 'Conceptual Platform', illustrated by Pearson et al., (2015) in the development of collaborative care for offender mental health. Here, the content of the matrix guides engagement with heterogenous PPS applicable across third generation evidence-based therapies. Findings were distilled further from Analytic Stage 5 through the evaluation's Analytic Stage 6, into a cycle of found common factors perpetuating PPS (Fig. 8.i). This was followed by the generation of principles of effective engagement disabling those perpetuating factors (Fig. 8.2) to meet an individual's personal PPS goals.

Moreover, the concurrent reflexive account of the therapy engagement also illustrated the flexibility required for interventions in naturalistic practice (para 8.4), showing why decisions were made and how the process of engagement, in response to the individual's story, moved along in practice. Moreover, the partnership between patient and therapist was shown in each case to grow from a mutual 'not knowing' to developing an understanding of individual patterns of response and to experiential change.

Furthermore, the quantitative descriptive analysis of the personal goal assessment of the four cases over time in therapy aligned with the qualitative material and live experience in the clinical encounters. However, this contrasted with the participants' lack of pre-post pattern in well-being and somatic symptom severity scores. The analysis shows that the PHQ-15 and WEMWBS failed to capture the stress-related impact of sexual PPS for these individuals and its significant disruption to close relationships. Consequently, this suggests the need for further consideration of the use of quantitative measures alone to plan or evaluate services because of their inability found here, to fully capture the baseline personal stress in relation to the PPS, nor the full impact of the therapy intervention.

The evaluation findings develop a greater appreciation of the predisposing precipitating and perpetuating factors of PPS and the substantial impact of personal distress on relationships. In this instance, the consecutively referred cases represent an exception to the majority, with high wellbeing and low somatisation scores. The higher reflexive analysis of the memos taken during and after the therapies showed a remarkable shift from high personal or relationship stress at the outset. The change was made by disabling the perpetuating mechanisms of PPS, enhancing personal resources resulting in part or complete PPS resolution. The focused therapeutic attention to one cluster of persistent symptoms in the relief of stress and worry and the recovery of natural physical function is richly illustrated. Chapter 9 makes a final critical discussion of the findings and offers a contribution to the enhancement of the Deary et al., (2007) expanded CBT model of autopoetic symptom maintenance.

Chapter 9: Final Evaluation and Discussion

9.1. Summary introduction and aims

The realist synthesis of the literature in Chapters 3 and 4 offered overwhelming support for the exploration of persistent 'medically unexplained' physical symptoms (PPS) as a complex subject, worthy of study within non-acute healthcare at individual and service levels. Concerns relating to real world complexity in relation to the PPS phenomenon (Abbass et al., 2014) were raised in the literature, along with the need for knowledge regarding the therapy process (Leichsenring, 2005; Bower and Gilbody, 2010) and for studies to identify the content and quality of interventions for PPS in the primary healthcare setting (Raine et al., 2002).

The realist literature synthesis combined with practice-based observations in generating the overall evaluation question: 'How and to what effect do the patient and therapist engage with PPS in non-acute healthcare?' In this chapter a final evaluation and discussion of the findings is undertaken relating by and large, to the 90% of PPS sufferers who do not fall into the Somatic Symptom Disorder (SSD) (APA, 2013) diagnostic category. Summary objectives shall include the critical consideration of the following:

- the realist literature synthesis in guiding the systematic exploration of process and outcome
- the role of the insider reflexive Therapist-Evaluator on the evaluation design the outcomes of a reflexive insider-Realist Service Evaluation (ri-RSE) on the development of clinical tools for upskilling for engaging with PPS in healthcare interventions with the contribution

of process findings showing the identification and disabling of the autopoetic maintenance of PPS

- the contribution to the definition of non-SSD PPS including sexual PPS and its outworking for underpinning clinical practice and policy
- the ri-RSE analysis of process and measured outcomes at service, caseload and depth cross-case comparison and the implication for service development
- the T-E reflexive statement: the ethical handling of this design
- the ri-RSE limitations and future clinical and research practice recommendations

9.2. Impact of the realist literature synthesis in guiding the systematic exploration of process and outcome

From the literature, the majority of persistent physical symptoms sufferers were found to fall outside the DSM-5 mental health categorisation of Somatic Symptom Disorder (SSD) (APA, 2013). SSD offers parameters of diagnosis to under 10% of the whole PPS cohort of those who are most severely affected by high health anxiety and excessive rumination. Under half of the whole cohort with PPS were found without anxiety and depression. If Cochrane Standard Systematic Reviews (Higgins and Green, 2011) alone had been used to explore the efficacy of interventions for PPS in healthcare settings the results would have been very different. The findings during the early exploratory stage of the realist literature synthesis, through an overview of systematic literature reviews from the period 2001-2014, recommended in the majority, that Cognitive-Behavioural Therapy (CBT) for PPS (as the most studied therapy by RCT) is superior to treatment as usual. CBT is therefore cited as the evidence-based treatment of choice (Deary et al., 2007; Kroenke, 2007). But personal practice-based experience suggested that the engagement with briefly applied psychodynamic principles (STPP) was working in practice in the relief of PPS in individuals and couples enrolling for therapy.

The realist literature synthesis was provided with a quality standard by the RAMESES guidelines (Wong et al., 2013 see Appendix 13). This equals other literature review quality standards making it possible to examine other forms of systematically developed evidence to find out what works for whom and in what circumstances (Pawson and Tilley, 2004). The search for efficacy and effectiveness of STPP approaches to PPS was facilitated by the underpinning realist epistemology (Chapter 2.4.) enabling both broad and deep examination of the literature. Furthermore, the commonalities across the practice of CBT and Short-Term Psychodynamic Psychotherapies (STPP) for PPS were discovered by this means.

Six systematic literature reviews showed efficacy for STPP interventions found in the publication period 2001-2014 (Appendix 11). Twelve primary studies were examined within date (2001-2014), and have enhanced by realist means, the Abbass et al., extensive literature review of STPP for somatic disorders (2009) by six further studies (Appendix 12). The realist synthesis of the literature (Chapters 3 and 4) provides evidence of the efficacy and the effectiveness of short-term psychodynamic principles for moderate and severe heterogenous PPS, at least equivalent to that of CBT compared to treatment as usual (TAU). The realist evidence showed STPP interventions as having moderate to high effects on mental wellbeing and persistent symptom reduction both post-therapy and in the longer term.

Moreover, in this process of realist literature synthesis, behavioural augmentations of STPP models were discovered (Chapter 4.5) to be similar to principles of practice used by CBT modalities for PPS (4.6). Furthermore, practitioners of CBT were found encouraging the evidenced-based inclusion of emotion-processing when addressing PPS (Woolfolk and Allen, 2007) through Affective CBT (ACBT). In this regard, ACBT is informed by the Experiential Therapies (Table 5. vi). Through wider reading, both major therapy modalities, Cognitive Behavioural Therapy and Short-Term Psychodynamic Psychotherapy were found to have diverged from their original psychoanalytic roots in different ways (Scott,

2009; Levenson, 2010; Coughlin Della Selva, 1996). The practices of third generation CBT and STPP were found to show convergence in the engagement with emotion and the application of behavioural techniques for persistent medically unexplained symptom sufferers, embracing a mindful, non-judgemental approach (Woolfolk and Allen, 2007; Sattel et al., 2012; Mayor et al., 2010). These findings suggested the examination of process and outcome could be analysed and subsequently understood from a cross-modality perspective.

9.3. The role of the reflexive insider Therapist-Evaluator in evaluation design and process

Firstly, the reflexive capacity of the Therapist-Evaluator (T-E) enabled insights derived from the literature synthesis to be acknowledged immediately within personal practice and to influence the evaluation design. The use of psychodynamic principles, over the years has been augmented at times by the T-E, with behavioural techniques adapted to the individual's presentation and relationship circumstances, showing the same pattern of augmentation as that was found to be effective in the literature across the main therapy modalities.

Secondly, the ontological and epistemological underpinning for Realist Evaluation (Pawson and Tilley, 1997) then opened the door to the systematic exploration of context, process and outcomes of the psychosexual counselling provision studied, at service, caseload and depth case level. This realist approach created an ethically viable container for the therapist-evaluator to explore in a naturalistic setting, important questions that arise both from clinical experience and from the realist synthesis of the literature. The evaluation design using the reflexive insider-Therapist Evaluator builds on insights and guidance derived from the protocol for the Systematic Case Study for Pluralistic Counselling and Psychotherapy (McLeod and Cooper, 2011) without disturbing the therapy. There are five types of psychotherapy case study outlined by McLeod and

Cooper: Pragmatic full case-study, Theory building, Adjudicational/ Hermeneutic, Narrative and Single Case Experimental design. Fishman's Pragmatic Case Study Method (1999; 2013) argues that two or more of these types can be further combined to enrich the case study findings, based on the mixed method research underpinning of Teddlie and Tashakorrie (2009). The reflexive insider-Realist Service Evaluation (ri-RSE) builds on Fishman and Messers (2013) argument for the Pragmatic Case Study Method as a way of crossing the therapy modality divide in practice. The ri-RSE embraces and further contextualises, at service level, the Pragmatic Case Study Method, without disturbing the routine therapy.

At the same time the ri-RSE enables theory building through a realist approach to the literature. It was possible, with reflection on the wider research findings against informal findings found in clinical practice, to discover common factors across two main therapy modalities for effectively addressing heterogenous PPS. This resulted in the theoretically derived preliminary cross-modality analytic framework which was underpinned by the Realist Literature Synthesis (Chapters 5.10-11 & 7.3).

The essential reflexivity of the therapist-evaluator ensures that study and personal preconceptions are made fully conscious at the outset and later reflected upon at each stage. These stages of the T-E reflexive function are shown with their outcomes (Fig. 5.2) and as such, were derived from lived experienced through the evaluation process from design to the final development of the findings. The power of the reflexive process in its contribution to the research/evaluation process are thus indicated.

Further, the enhanced qualitative analytic protocol was defined by six discreet stages. These analytic stages were illustrated by the Therapist-Evaluator's frank, reflexive account of the opportunities and challenges found within the evaluation process (Chapter 7.3-7.5).

The rare depth and breadth account of the realities of undertaking an insider evaluation has both revealed and highlighted the essential components of the evaluation design. The experiences of the insider T-E in undertaking a Realist Service Evaluation act as a guide for future therapist-evaluators who may wish to implement the ri-RSE methodology in practice to explore questions arising within the clinical setting.

9.4. Impact of the ri-RSE on the development of guidance for practice

The culmination of this reflexive insider-Realist Evaluation (ri-RSE) and its contextualised findings facilitates the development of theory and guidance to underpin psychotherapeutic interventions for non-Somatic Symptom Disorder (SSD) presentations of PPS in non-acute healthcare settings. Overall, these literature and contextualised practice findings contribute to a realist 'Conceptual Platform', as previously described by Pearson and colleagues (2015), of principles derived from research and practice to guide, train and enhance services to deliver effective PPS interventions.

It was not possible to fully identify at the outset a universally agreed realist 'Programme Theory' (Pawson and Tilley, 2004) for PPS interventions. However, the early development of IAPT Wellbeing services for PPS (IAPT, 2014) positive practice guide, was found largely to be based on the Systematic Reviews of efficacy of CBT interventions for PPS co-morbid with anxiety and depression. IAPT talking therapists have been found to request further skills training and specialist supervision for this role (De Lusignan, Jones et al., 2013). Low intensity, supported self-management for those without anxiety and depression is recommended by IAPT stepped care. No evidence base for this latter decision was found provided (IAPT, 2014). Those with high levels of disability and significant medical or mental health co-morbidity are currently recommended intervention within specialist services or by Liaison Psychiatry, and this is roundly supported by research collated by Creed et al., (2011).

Therefore, the realist Context, Mechanism, Outcome (CMO) equation for the discovery of PPP factors of PPS emerging from the ri-RSE project is presented (Table 9.i) as offering an initial contribution regarding the early therapy process with PPS sufferers with at least one disruptive physical symptom with or without concurrent anxiety and depression.

Table 9.i) CMO Early discovery of Predisposing, Precipitating and Perpetuating factors (PPP)

Context **PLUS**	**Mechanism of engagement** **PLUS**	**Cycle of continuing engagement =**	**Outcome finding**
Open invitation to engage with PPS	Invitation to expand on their own story	Taking the patient back again to when the PPS started	Precipitating factors
Taking a brief medical and social history back to early life: noting challenges	Eliciting past experience of PPS	Reflecting back the therapist (emotional and cognitive) response to what is said	Predisposing factors
	Exploring impact of the PPS on self and relationships	Exploring desired change. Use of shared reflexivity to guide goal development	Perpetuating factors

Moreover, Practice Based Evidence derived from the ri-RSE highlights by whom and in what context is shown to facilitate the discovery of the predisposing, precipitating and perpetuating (PPP) factors of PPS (Table 9.ii).

Table 9.ii) Realist CMO of principles of engagement for disabling PPP

Context	Mechanism	Outcome
Qualified and registered psychological therapist addressing the PPS in a spirit of genuine collaborative enquiry in the context of the individual's personal medical and social history within a non-acute healthcare setting	In partnership, developing a psycho-physiological approach to PPS over time in therapy Deep listening, recognition through the patient's story of natural survival mechanisms and consequential heightened sensitivity to perceived threat, validating negative emotion and past experience, developing practical choices, reviewing and building on progress.	Disabling of PPS factors Reduced worry and anxiety over the PPS Increased trust in self and others Substantial progress towards personal PPS goals for therapy

Authors have hypothesised about the aetiology of persistent physical symptoms within therapy modality specialisms, medical research and practice and from philosophical perspectives (Mc Dougall 1989; Berrol, 1992; Rothschild, 2000; Sidoli, 2000; Zalides, 2001; Damasio, 2003; Brown, 2004; Hartley, 2009; Broom, 2009; Watkins, 1997; Hellhammer and Hellhammer, 2008; Greco, 2012). Taken as a whole, literature review reveals that the search for an explanation for PPS is wide. Within this intervention an appreciation of essential psychoneurobiological research (Pert, 1997/1999) combines with the focus on the uniqueness of the individual and his or her past and present inseparable physical, cognitive and emotional perception.

During the study, both the common perpetuating factors and practice-based evidence of the process of disabling of common factors perpetuating PPS became clear through Analytic Stages 5 and 6 (Chapter 5.11.2). This took place after the abductive qualitative data analysis through a higher reflexive process both during and after the therapies. Commonalities and difference were examined across the four cases. This

process illustrates philosopher Peirce's realist view that the logic of abduction in the creative analysis of qualitative data, represents in itself, a logic of discovery (Honderich, 2005). The ri-RSE therefore, has further delivered a summary of common patterns found perpetuating PPS (Fig. 8.1) and a summary cycle of cross-therapy modality principles of engagement with PPS found to disable the perpetuating PPS factors in practice (Fig. 8.2).

Finally, the preliminary, theoretically underpinned qualitative analytic framework (Table 5.vii) was built through the ri-RSE process into an indicative, generic, guiding cross-therapy modality Matrix of Engagement (Table 9.iii) for real-world practice. It is observed that the intention of this guiding matrix should remain as an ongoing flexible and cyclical process of engagement across the therapy sessions. The Guiding Matrix of Engagement seen previously proposed (Table 8.ii), now directly informs and guides the reader 'how' a cross-modality therapy intervention that effectively engages with the individual and their PPS, might be undertaken.

It is seen that the Generic Guiding Matrix of Engagement with PPS (Table 9.iii) generated from a flexible patient and therapist interaction, identifies several focus points for skills training and in turn, may be used to underpin the future assessment of skills acquired when addressing heterogenous PPS within non-acute healthcare settings.

Table 9.iii) Generic Guiding Matrix of Engagement with PPS

Themes	Content				
Engage the Therapeutic Alliance	Generate hope	Give and get information	Invite to expand on story	Develop the patient-therapist partnership	
Explore the nature of PPS/PPP & initial goals	Scan for potential predisposing factors (P)	Discover precipitating factors (P) (What brought you here/how did it start?)	Understand the detailed nature of the PPS complexity (How and when does it happen?)	Develop awareness of perpetuating factors (P) (What blocks recovery?)	Value linked emotion (Does the PPS still have a purpose?)
Use therapist reflexivity	Observe for loss of feeling	Reflect on presentation of patient self	Observe involuntary shut-down	Note defence and protection of self and other	Note the extent of not telling
Use symbol and metaphor	Initiate joint expansion of meaning	Embrace the person's expansion of meaning	Use symbol and metaphor to challenge	Return to metaphor for expansion of meaning	
Act with sensitive attunement	Acknowledge pain and distress	Accept the subjective view and use person's own words or examples	Look at wider patterns of response together	Explore any link from the wider patterns of response to the PPS	Use therapist self to mirror the impact on self and others
Validate emotion	Clarify and validate present feeling	Explore past feeling & any previously unacceptable fact	Engage reflexively with any internal conflict		
Develop cognition relating to emotion and the PPS	Acknowledge & accept emotion	Develop awareness of individual self and others in relation to the PPS	Listen to past experience	Observe responses to wider life examples	Find the core hurt
Trial of person-matched behavioural interventions, note responses	Agree PPP factors that may contribute to the PPS to match to behavioural interventions	Recognise contradictions & consequences relating to what is said and what is done	Challenge patterns of response	Recognise blocks to change	Value both person readiness or non-engagement
Develop experiential change	Facilitate cycles of self-awareness	Make changes in ways of doing through goal focus	Develop confidence through goal assessment reviews	Validate what works	Find out with the Pt. what they need next
Check acceptability of the intervention	Ask how the intervention is being experienced	Acknowledge personal perspectives, respecting need for further change	Give non-judgmental space for the expression of negative and positives	Review focus/ Celebrate change, recognise 'good enough'	Agree how any remaining work will be done

This realist evaluation has attempted to synthesise what works, rather than to stay with individual theses of aetiology and intervention modality. Without a synthesis of the wider literature, previously there was an uncertainty concerning 'what works for whom and how' when faced with complex healthcare needs and sufferer experience. To this end, the process findings of this realist evaluation are offered in the following section as a further development of Deary et al's., expanded CBT Model of the autopoetic mechanisms of PPS perpetuation (2007).

9.5. Contribution to process of disabling the autopoetic maintenance of PPS

Realist researchers suggest that it is a combination of factors, which generates an outcome and that a defined input does not necessarily lead to a predicted output (Marchal, 2012). This ri-RSE has led to the higher thematic reflexive analysis of engagement between patient and therapist and to an overall synthesis of principles of engagement as seen above.

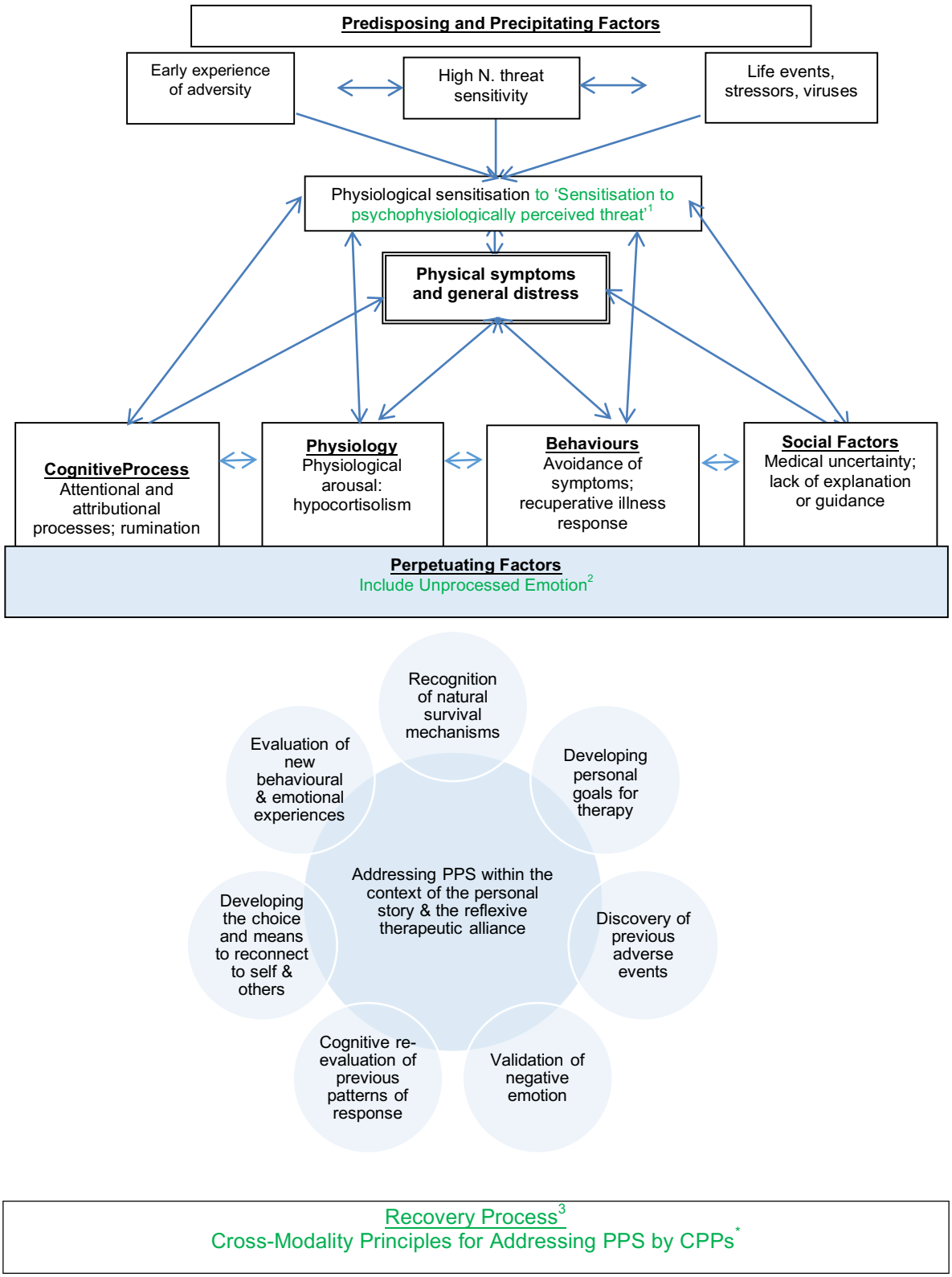
The transparently and systematically developed practice-based knowledge from the study responds to Deary et al's., call for the detailed study of processes of engagement that effectively disable the autopoetic maintenance of persistent physical symptoms (2007). The CMOs (Tables 9.i & 9.ii) provide an accessible, albeit simplistic, synthesis of the type of engagement and professional attitude that have been evidenced. From this ri-RSE, the findings combine to offer an extension of Deary et al.'s (2007) expanded CBT Model of hypothesised autopoetic cycle of symptom maintenance (Appendix 17) (Fig. 9.1). As Common Factors are extracted as propunded by Laska et al., (2014) in the endeavour to improve psychotherapy practice, this arguably results in delivering Constantino and Bernecker's (2014) 'Context Responsive Psychotherapy Integration'.

Suggestions for the extension of Deary's model arising from the Realist Evaluation findings are presented relating specifically to non-Somatic Symptom Disorder cases:

1) Following Predisposing and Precipitating Factors, rather than Deary's 'Physiological sensitisation and distress intolerance', threat sensitivity has been found to be more accurate for PPS, suggesting, 'Sensitisation to psychophysiologically perceived threat' (i.e. based on the innate drive for survival and below conscious awareness)[1]

2) The inclusion of 'unprocessed emotion'[2] within 'Perpetuating Factors'

3) Extending to 'Recovery Process': A cycle of cross-modality guiding principles (transferred from Fig. 8.2) for Counsellors, Psychotherapists and Psychologists[*] (CPP) to engage with the predisposing, precipitating and perpetuating mechanisms of heterogenous non-Somatic Symptom Disorder PPS[3].



9.1. Proposed extended model of an autopoetic cycle of PPS with potential recovery process

9.5.1. Contribution to realist 'acting agents' for resolving PPS

The emergent service evaluation question of this research, 'How and to what effect do the adult patient and therapist engage with PPS?', was set within the context of general service-level and the micro-specific cases. The resolution of PPS, evidenced in Chapter 8 whilst exploring the precipitating, predisposing and perpetuating factors of PPS has been observed to empower the individual. This is achieved through a joint psychophysiological interpretation of the messaging of the body so as to develop insight into choices of future action, liberating a personal creativity to effect change despite past and current circumstances. This process aligns with realist philosopher Bhaskar's view of personal agency (1998; 2008). The ri-RSE also offers further clarification of Pawson and Tilley's (1997) 'acting agents', making the observation of movement towards change possible. The therapy process moves from the position of:

- observing what is happening now
- exploring why things are as they are, whether the individual feels they have the power or agency to act to make a difference
- discovering the informal rules that have led to a feeling of powerlessness to effect change

To facilitation towards recovery by activating between patient and therapist

- a non-judgemental challenge of those rules over time, using the developed psychophysiological insights that apply
- the experience of physical and emotional change for the better
- self-resourcing to act on what matters uniquely to the individual now and in the future

9.6. Contribution to the definition of Persistent Physical Symptoms

Through the realist synthesis within the literature and the context, process and outcome findings, a contribution to the definition of non-SSD persistent physical symptoms is made possible. This offered definition is for the non-ruminating individual with PPS, of at least six months duration, excluded from the DSM-5 classification of Somatic Symptom Disorder, who is willing to explore the reasons for their unique PPS, found as unremitting and unresolved. These latter descriptors imply that something other than treatment as usual is now required. The words 'unremitting and unresolved' also genuinely acknowledges the difficulty for the individual and healthcare provider who may feel there are few resources available to secure any kind of recovery. The exclusion of serious disease processes remains a priority and continues as clinically indicated (Bermingham et. al., 2010). From the results of the realist evaluation, the person with a minimum of one subjectively troubling physical symptom of dysfunction of at least six months' duration, with no identifiable disease-based or age-related pathology is shown as deriving substantial benefit from a short-term joint exploration into cause and perpetuation.

Moreover, it has been observed in the study that, for an individual whose personal manifestation of PPS is mutually explored and addressed not as a dysfunctional response nor as a symptom syndrome but as a natural protective human response to adversity has advantages. Significant progress towards personal goals over time in therapy has been systematically evidenced (Chapters 6.6 & 8.7). Also the engagement process is shown through the higher reflexive analysis to equip the individual, by enhancing his or her personal agency, to realise 'good enough' personal goals. In the sample cases, when exceptions and change begin to be experienced, there is no longer the pressure to engage in the debilitating and costly cycle of repeated medical

investigation nor the resignation to chronic symptom management, but rather, self-encouragement to take personal control over ‘what works’.

9.6.1. Persistent sexual symptoms as PPS

Sexual dysfunction has been absorbed into the specialism of sexology within medicine and psychotherapy and is scientifically researched within its own boundaries. These research outcomes have been published in specialist journals such as the Journal of Sexual and Relationship Therapy and the Journal of Sexual Medicine, building knowledge on sexual behaviours and therapeutic interventions. As with all specialisms, the paradox of this is that this material is hidden from the generic healthcare professional who refers to the specialist as ‘good practice’. As happens with cross-healthcare discipline persistent physical conditions, the individual can be sent in many different directions, finally ensuring that no-one sees the whole person or hears his contextualising story (Bermingham et al., 2010). The difficulties with sexual function, which at times need specialist referral, have been shown by depth exploration in this evaluation as another form of survival-related PPS. Thus, unremitting and unresolved sexual symptoms signal, as with other PPS, the need for a contextualised person-focused, mindbody-event related joint interpretation.

Sexual PPS is recommended through the findings of the ri-RSE for inclusion in all generic somatic symptom measures. Equally the findings of this evaluation call for sexual medicine and therapy specialists to enquire about other PPS within their consultations. This will support a wider view on the physical impact of unresolved emotion or hidden stress on intimate relationships and sexual function. The study shows that the professional and personal awareness of the psychophysiological underpinning of heterogenous PPS results in a wider appreciation of the individual’s contributing factors. Additionally, the potential of value-added interventions indicated by the findings, that embrace PPS in routine talking therapy consultations, will again enhance personal resources, reduce

unnecessary medical investigations and promote self-efficacy towards a better health.

9.7. Contribution to service development and healthcare policy

Realist evaluation is the research method that is ideally placed to underpin the development of policy when an appreciation of context plus the intervention mechanism can be activated in similar settings in order to achieve effective outcomes (Pawson, 2002). This realist research has systematically generated cyclical cross-therapy modality principles for guiding clinical practice with PPS. Its adaptation to similar practice settings is quite evident. The exploration of the context of the PPS and the intervention, along with the details of service delivery of therapy and the process of engagement towards an individually owned resolution of PPS, offers the potential of transferability to similar practice settings.

There is now a cumulative understanding through psychoneurobiological and immunobiological research, of a clear link to the influence of emotion on physical function (Pert, 1997; Hellhammer and Hellhammer, 2008). These research findings demand that there is a continued consideration of a 'psychophysiologcal' medico-cultural model in the conceptualisation and treatment of persistent physical symptoms.

Healthcare professionals as practice-based evaluators and researchers are increasingly urging a re-consideration of the treatment of persistent physical symptoms beyond the biomedical and the biopsychosocial model of medicine (Watkins, 1997; Read, 2005; Rothschild, 2000; Sarno, 2006; Clarke, 2007; Oldfield, 2014). Moreover, healthcare researcher Al-Kashi helpfully demonstrates the comparisons between three medico-cultural models and their impact on attitudes to illness and outcomes (Table 9.iv).

The advantages of the psychophysiological model are made clear regarding the potential of recovery from persistent physical symptoms.

Table 9.iv) Summary of contrasting aspects of medico-cultural models

Medico-cultural model	Bio-medical Model	Bio-psychosocial Model	Psychophysiological Model
Attitude to illness	Brokenness to be mended	Influenced by environment and behaviours. Health is good management of chronic conditions	Health is recovery. Direct mind-body connection
Therapeutic Alliance	Authoritarian	Collaborative	Psychoeducational
Attitude to PPS	Suppression of symptoms	Preventable or incurable	Illness is an expression of unconscious emotional trauma
Negative consequence	Reduces human to machine	Patient as customer and incurable expert	Body reduced to psychological expression only

(adapted from Al-Kashi, 2015)

Increasing online publication of self-help guidance by medical and professionals who are allied to medicine to advise on 'what works' in practice to ameliorate chronic conditions is found. This is in particular, on the subject of stress-related chronic persistent pain and physical dysfunction (Clarke, 2007; Schubiner and Betzold, 2010; Oldfield, 2014;). These professional discoveries of 'what works' in practice unite the physiological and the psychological in the recognition of their two-way impact on health at cellular level as shown by Pert, (1997). Thus, the findings of the realist service evaluation support this notion.

The current reach towards 'parity of esteem' for mental health supported by the NHS England planning guidance, Delivering the Forward View (2015), although laudable and long sought, unwittingly again mitigates against an integrated psychophysiological perspective on PPS by only

providing one to one therapies for those PPS sufferers who are comorbid with anxiety and depression.

The ri-RSE has shown the value of one to one therapy for a minimum of one presenting PPS for which an individual is seeking help within a non-acute health service setting. There has been little published account of preparation for talking therapists to address PPS with or without poor mental health (De Lusignan, Jones et al., 2013). The ri-RSE findings offer an evidenced contribution to underpin transformation into action of care redesign as urged by NHS England (2015) in relation to the substantial impact of unresolved PPS on NHS resources (Bermingham et al., 2010; Nimnuan et al., 2001).

9.8. Contribution to the psychotherapy measures debate

9.8.1. Warwick & Edinburgh Mental Wellbeing Scale

The ri-RSE demanded the scrutiny of process and outcome measures of mental wellbeing and somatic symptoms. The reasons for selecting the routine measures for the service were discussed in Chapter 5.6. The positive mental wellbeing language of the Warwick and Edinburgh Mental Well-Being Scale (WEMWBS) was found to be a good fit with the preconceptions of the study and specifically with the patient population attending for healthcare interventions to improve their overall wellbeing. 'Important change' in wellbeing was evidenced from the middle (Time 2) to end of the therapy (Time 3) across the caseload studied.

In the four consecutively referred depth cases, all happened to have higher than caseload average wellbeing scores. Yet, it became evident during the therapy process that for each, there was considerable stress-related, personal and relational disruption linked to their predisposing, precipitating and perpetuating factors of PPS that were not picked up by the wellbeing score. This may suggest the following possibilities that:

a) the WEMWBS is insensitive to particular types of stress

b) the stress or conflict only comes into individual conscious awareness through the therapy process
c) the individual is able to compartmentalise the stress or conflict linked to their Persistent Sexual Symptom, as separate from day to day functioning

9.8.2. Somatic Symptom Severity Patient Health Questionnaire-15

The Patient Health Questionnaire (PHQ-15) was selected as the most accessible tool to screen for somatic symptoms, which included over the last four weeks, 'pain or problems during sex' (see Appendix 5 and Chapter 5.6). On review, the tool was able to raise clinician awareness of persistent somatic symptoms across the service and also to see how the presenting persistent sexual symptoms aligned with other PPS. Again between T2 and T3 important change was found.

Additionally, it was noted in practice that the PHQ-15 question regarding persistent sexual symptoms, in the last four weeks, 'How much are you bothered by pain or problems during sex?' was answered variously. It was noticed that if an individual had not had sex in the previous four weeks due to their problem, this would not be recorded as bothersome and yet they had come for help for this reason. However, after an initial trial, two further questions regarding sexual interest and arousal were added as extra to the PHQ-15 scores so as not to disturb its validity, but were not reported for this evaluation. Despite of this addition, there is evidence that adds to the requirement that further research is undertaken to develop an adequate 'sexual difficulty' question in the context of 'medically unexplained' symptoms within the PHQ-15. Once clinical staff were educated as to the incidence of PPS across the population this knowledge was shared individually with patients. Their sexual and other PPS were tentatively appreciated as possible physical manifestations of personal stress or hidden conflict which was then explored within context.

As a service team we are now considering ways by which we can align our service measures with national outcomes. This complex task of evaluating outcomes is debated at 5.6.1. and the endeavour to find a generic outcome measure for heterogenous interventions for sexual dysfunctions continues with the National Sexology Outcomes Group (NSOG) to which this service now contributes.

9.8.3. The relationship between PPS and wellbeing at baseline

The two previously validated measures, WEMWBS and the PHQ-15 were used on the participants to observe for a relationship between mental wellbeing and symptom severity at baseline as had been highlighted as relevant in the research literature. These were found negatively correlated with moderate significance, thus pointing to continued vigilance for the causes and treatment of anxiety and depression, but equally suggesting that PPS do not necessarily have this co-morbidity, but nevertheless deserve skilled therapy intervention.

9.8.4. Goal Assessment

The Goal Assessment Form (GAF), University of Strathclyde (Appendix 4 & 5) proved to be an effective visual tool that would show change on the form's Likert 7-point scaling over two or three time points in therapy. With the aid of the scale, patients grow in confidence as they see this confirming progress; patient and therapist are able to value the change. Where there was no change an alignment to the Lambert et al., (2001) and Lucock et al., (2003) examples of addressing blocks in therapy, the therapy was as a consequence adjusted in order to meet individual need. This goal assessment measure reflected clinical outcome findings more clearly than the wellbeing and symptom severity measures. The GAF was found to be a useful tool to guide co-working towards personal goals during the therapy and facilitate the individual to own the outcome. The tool also indicated any ongoing needs and how these might be addressed by the individual in the future.

9.8.5. The Experiential Therapy Session Form

The Experiential Therapy Session Form (Elliott, 2002) Section I (CESP) (Appendix 5) was used to support session reflections. To this the T-E added a shorthand form of Rolfe's reflexive cycle. Sections II and III of the CESP looked at how the patient engaged with the session and how well the therapist thought it went (Appendix 5). The data from Sections II and III did not prove useful without the Helpful Aspects of Therapy Form, (HAT) (Elliott, 1993) which is given to the patient after each session in Experiential Therapies' research designs. Also, for the realist service evaluation the T-E was given NHS employer approval to make use of routine service measures and could therefore not include the HAT form which may have altered the nature of the intervention in unseen/unknown ways. I was also therefore unable to find the Overall Session Ratings of Elliott's (2002) Section II nor the Client Modes of Engagement Section III of support in this study. I would like to present the limitation that I had not been trained in their use, which in retrospect might have altered my perception of functionality. However, I found myself unable to rate the session by the terms given, as the intervention undertaken was a cyclical process that was unfolding over time. There was a continuity in the therapy, with each session found interconnected with the last and the following one. Consequently, to fully or even momentarily evaluate the impact of an individual session became genuinely impossible. Additionally, lags in between therapy sessions produced more change and events external to the therapy session were indicative of their un-measurable influence on progress towards achieving goals for therapy. Therefore, the data from Sections II and III, intended as backup if needed for the analysis was not used.

9.9. The responsibilities of the ri T-E for ethical conduct

The issue of ethical conduct for the insider therapist–researcher applies not only at the evaluation design stage and for gaining ethical approval. A concern over the lack of research governance over ethical issues arising in practice is identified by Preston-Shoot et al., (2008) highlighting the need for continued vigilance. The authors suggest that theoretical ethics guidance requires practical application 'at the practice edge' throughout the evaluation-research process. At the outset, the T-E's professional ethical framework for practice and research (BACP, 2015) was necessary to support the development of an ethical consent process keeping the core issues of the protection of sensitive personal data, harm reduction and participant autonomy in mind. This was found commented on by researchers of sensitive research subjects (Saunders et al., 2015a) and psychiatry (Levine and Stagno, 2001) through to the publication of the results. It was also recognised therefore, through depth reading, that it may be an impossibility in reality for the insider T-E to take a fully informed consent from potential participants. Returning to the professional ethical guidelines throughout the evaluation was necessary to support the resolution of further ethical dilemmas.

9.9.1. The ri T-E: reflexive statement on ethical issues arising

There were ethical concerns addressed in decision-making throughout the project. However, the following are given special account so as to avoid unintended breaches in confidentiality (Bond and Mitchels, 2015; DH, 2003:35). The issue of potential exposure of sensitive data had, in retrospect, to be considered for all contributing participants which included service colleagues. This generated two serious reflections concerning privacy, individual autonomy and harm reduction. The BACP Research Ethical Guidelines (BACP, 2015, Point 5) (see Chapter 5.2) were found profoundly supportive in underpinning the following reflexive ethical review.

The first reflection addresses an unintended potential breach of confidentiality which was found before the publication of findings.

What? Firstly, the T-E had not recognised a potential breach of confidentiality at the service level. Despite the perception that a descriptive aspect of intervention providers would not cause personal harm given the current social climate but would add to context, there was potential that an individual might be re-identified by the initial account of therapist characteristics.

So what? Moreover, the T-E's personal attitude could not override current English law in the form of Data Protection Act, 1998 which clearly defines types of sensitive personal data. The possibility of re-identification and potential harm to the individual is articulated by the English Information Commissioners Office (ICO) for organisation and project identifiable data collection (2012) and triggered the need for careful checking for a potential breach throughout the thesis.

Now what? The solution advanced by the ICO is the careful anonymisation of data so that it reduces by every means, the possibility of re-identification in the future, giving practical examples of how this might be done (ICO, 2012, p. 16 & Annex 3.). This anonymisation was effectively retrospectively put into place and anonymisation further adjusted for all the participants. Only critical aspects of thoroughly anonymised personal data were retained to give a true analysis on the subject of study.

The second reflection addressed complex issues of publication of sensitive subjects even with consent.

What? The issue of publication was revisited by the T-E. The participants had all consented to the publication of verbatim extracts (Appendix 7) for educational and service development purposes with the opportunity to request a review of these extracts. At the end of the therapy contract each

participant was asked if they had any concerns or questions over their participation or future publication of extracts and asked if they would still like a summary of the Service Review findings. All said that they trusted the anonymisation of their personal data by the T-E, none retracted their data or asked for it to be reviewed. However, one participant firmly declined to receive the summary of findings but the remainder agreed that if the T-E wished to send a summary, they would be happy to receive it.

So what? The re-evaluation of potential harm to participants through publication (Levine and Stagno, 2001), even when consented (Vollman and Helmchen, 1996, in Levine and Stagno, 2001) and the balance of 'enhancing the quality of professional knowledge and its application' (BACP, 2015) generated T-E concern and required much reflection regarding future publication.

Now what? The guidance for resolving ethical dilemmas given by the BACP Ethical Framework (2015) advises that if an ethical dilemma is strongly supported by at least one of the research principles for counselling and psychotherapy without contradicting the others, such a decision is considered 'well-founded' (Chapter 5.2). The T-E reviewed and adjusted where needed, all the data sets and came to the conclusion that in this instance, through honouring the trust placed in the T-E, every precaution against breach of confidentiality, minimisation of harm, justice and practitioner self-respect has been taken through to publication. The T-E remains accountable (BACP, Point 7).

These need for these serious reflections was sobering given their unintended nature. Research review by examiners for quality and safety is critical to the discovery of any researcher blind-spots. However, exploring the ethical implications by wider reading on researcher experiences and consultation with Professional Ethical Guidelines secured a rational outcome in both instances. The T-E hopes that this account will support other therapist-evaluators in the future and links to the following section.

9.10. Dissemination of results

Dissemination of systematically derived practice-based evidence within a realist service evaluation is initially and ultimately the ethical responsibility of the evaluator (BACP, 2015; ICO, 2012). The careful dissemination of such sensitive findings has the potential in this instance, to contribute to the transformation of healthcare interventions for PPS sufferers. A shift in conceptualisation made from the biopsychosocial model of health and illness (Table 9.iv) to one that acknowledges and addresses the unity of mind-body and emotion in response to life events is shown to be important. It has been found with such perspective, that healthcare professionals can transform their own and their patients' frustration by jointly taking an integrative pathway to better health. Additionally, a psychophysiological approach offers non-judgmental explanation paired with the expectation of change for the better. This is achieved through discovering the mechanisms of PPS perpetuation with the individual by skilled and respectful exploration. This process has been evidenced by this study to enhance the personal potential of patient and healthcare provider to begin to positively engage in the journey towards relief of heterogenous, persistent physical symptoms.

It is anticipated that dissemination of the findings will enhance professional and patient user groups' awareness of future opportunities for potential symptom resolution. Dissemination of the principle findings, continuing to respect participant privacy and anonymity will be to:

- the organisation's relevant executive boards
- local health and social care commissioning boards where relevant
- regional and national providers of wellbeing interventions
- regional and national providers of psychosexual therapy
- local and national INVOLVE group by invitation
- research and professional development conferences

It is also planned that dissemination of results will be undertaken in the near future by consultation with academic supervisors and employing sponsor to:

- publication of findings in professional journals
- distributing a summary of findings to professional organisations and key policy-makers

9.11. Limitations

As has been found, all study designs have their limitations and accordingly so does this study. As in the realist philosophy of Peirce (Hondereich, 2005) all knowledge is partial and in the real world of clinical practice interventions, the knowledge is context dependent. The capture of content and action, which is the process of engagement, generated within different psychotherapy interventions, is a particular challenge to explore systematically and ethically in naturalistic practice settings as a prospective exercise. The research findings of this particular evaluation are therefore:

- limited to a particular therapy intervention in a particular service setting at a particular time

Further, the study of personal practice was a great challenge to execute, and it required reflexive function, regular consultation and purposeful ethical design to reduce inherent bias and potential harm. For the ri-RSE, the patient cohort of study were defined by their referral for help to resolve persistent sexual dysfunction and thus the argument that sexual PPS has similar features compared to other PPS requires strengthening. The ri-RSE limitations are also:

- boundaried by the use of particular routine measures

During the study analysis, the measures used were carefully pre-selected but due to the nature of service evaluation only routine measures could be

used so as not to disturb the intervention. These measures were complimented by the qualitative analysis broadening the evidence of change. During the analysis, PHQ-15 sexual difficulty question was found inadequately constructed to ensure a consistent response confirming van Revesteijn et al.'s (2009) finding that a factor analysis of the PHQ-15 showed that 2 symptoms were only weakly associated with the following: menstrual problems (item-total correlation [ITC] 0.26) and sexual pain/problems ([ITC] 0.18). Thus and so, sexual and menstrual symptoms were excluded from the van Revesteijn study. This illustrates how persistent sexual dysfunction becomes side-lined from somatic symptom scales, rather than further researched. Consequently, a valid sexual symptom measure is still awaited (Twigg and Mellor-Clark, 2013). Additionally, the wellbeing measure, WEMWBS has no researched cut-off scales for anxiety, but does so for depression. This could be argued as a measure short-fall for the study. The findings are further

- unconfirmed by a full consensual analytic process (Hill, 2012)

Due to the position of the T-E as research student, the data analysis was presented in transparent detail (Chapter 7.5 and Appendix 15) and regularly reviewed by academic supervision and is

- inevitably influenced by the evaluator's background and preconceptions

The reflexive function, which was integral to the realist service evaluation design, facilitated an openness regarding the T-E's preconceptions and choices regarding the direction of the analysis. It has been seen that this issue of bias in the role applies also to all other research processes and is rarely examined in detail. These concerns were addressed ethically in the methods design and through the integral nature of the reflexive function. The need for a pragmatic approach to studying naturalistic practice, process and outcomes where the PPS phenomenon was being actively

addressed were therefore limited to the T-E's own service intervention. The findings in this study were

- not possible to evaluate over the longer term

Due to the research design being a realist service evaluation, the structure and sensitive nature of the service and the reality of time constraints, it was not possible to undertake the ideal of the post-therapy interview and longer term measures (McLeod and Cooper, 2011).

9.11.1 Advantages of the reflexive insider-Realist Service Evaluation

The detailed account of the reflexive insider realist-evaluator shows the checks and balances that were put in place to reduce the impact of personal and structural bias and to resolve transparently, any ethical issues arising (Chapter 2.6, Chapter 5). The danger of generating an unconsciously skewed or manipulated therapy relationship was also considered in-depth in Chapters 2 and 5 in the recruitment process and care of the evaluation participants and T-E.

Realist Evaluation demands that there is a scrutiny of context (Chapter 6, 7 & 8) and articulation of the mechanisms of an intervention, which leads to change, with a comparison of some kind (Marchal, 2012; Wong et al., 2010). The transferability of findings is made clear through the thorough examination of the context of the evaluation with comparison to other talking therapy service providers. In this instance, during the evaluation, individual cross-case comparisons were also made suggesting that the PPS sufferer with early life adversity may need more than one episode of therapy (Chapter 6.5.5, Chapter 8.7). However, the developed principles of engagement applied in all cases.

Consultation with stakeholders, integral to Realist Evaluation has been shown (5.1.3.) and a transparent account of the workings on the development of findings given (Chapter 5.10 and Chapters 7 & 8),

culminating in underpinning for service and policy development. The added structured reflexivity enabled the therapist-evaluator role not only to become ethically viable, but to meet previous research recommendations for the systematic prospective exploration of therapeutic process and outcomes relating to PPS.

Despite the limitations, the study observes that this realist evaluation method (ri-RSE) has produced complex and hard to reach, much needed findings on the contextualised lived experience of how the perpetuating mechanisms of (non-SSD) PPS can be disabled. It gives an indication of the resources and attitudes required to do so in a real-world, non-acute healthcare setting.

9.12. Future research and practice recommendations

The systematic development of in-depth knowledge from a healthcare service intervention, from the insider practice-based perspective is rarely found at such depth. This can be attributed to its complexity and time involved in undertaking a systematic analysis with the recommended use of a consensual analytic process (McLeod and Cooper, 2011) for the psychotherapy case component. However, when truly insider material is systematically explored and the process and outcome findings are reported to published standards, the material is found readily transferrable to other settings. The findings presented can be built upon by further ri-RSE and also by case study evaluation methodologies such as the Pragmatic or Systematic Psychotherapy Case Study embracing measured outcomes (Fishman, 1999; Datillo et al., 2010; McLeod and Cooper, 2011). Furthermore, mixed method studies of patient experience, in this instance of the engagement with PPS, as argued by Pragmatic Case Study researcher Fishman, (2013) will also inform and complement any future RCT designs. The following recommendations emerging from the ri-RSE methodology and methods for future research and practice are given:

- therapist-researchers can now consider the utility of the reflexive insider-Realist Evaluation methodology for Practice-Based knowledge creation within a service setting
- research output across all research designs would benefit from a researcher-engagement with structured reflexivity to reduce bias in findings
- further ri-RSE cross-modality therapeutic process and outcome research on PPS interventions to enhance theoretical and practice insights
- somatic symptom measures such as the PHQ-15, are encouraged for use in routine clinical practice
- adequate factor analysis on question(s) concerning persistent sexual symptoms within somatic symptom measures used in routine healthcare practice
- qualitative research on patient experience of therapy interventions for PPS within IAPT services

Recommendations for policy and practice:

- simple measures of anxiety, depression and somatic symptoms used to benchmark across all services addressing health issues
- resourced development of effective skills for addressing PPS in therapy caseloads
- the individual receiving healthcare interventions is effectively resourced and supported by qualified therapists to develop and reach personal goals in relation to PPS
- measured progress towards personal goals concerning PPS assessed and reported more widely within non-acute services

This realist service evaluation and the intervention studied has shown that the significant population of non-ruminating persistent physical symptom sufferers with at least one bothersome PPS could be readily helped by a skilled one to one generic intervention in non-acute healthcare settings.

Thus, to achieve this, the following is further recommended for enhanced service delivery for PPS in England and Wales:

- Clinical Commissioning (CC) facilitation of awareness raising and effective upskilling of frontline primary care staff
- Wellbeing services taking responsibility to enhance the substantial skills of 'talking therapists' in relation to addressing PPS in practice
- CC and Wellbeing Services placing Counsellors, Psychotherapists (BACP, 2014), Clinical Psychologists and CBT practitioners in primary/community care with liaison links to specific GP practices
- A CC/NHS England funding to support the roll-out of awareness and enhanced skills training across all primary care and community healthcare professionals with face to face patient contact
- CC Groups (CCGs) to expand on the NHS Plymouth Medically Unexplained Symptoms Whole Systems Approach (IAPT, 2009) (Creed et al., 2011) by identifying a Clinical Lead for PPS within each healthcare provider organisation
- CCGs/NHS England to support the development of Psychiatry Liaison to support Family Physicians in the care of the 10% of PPS sufferers within the Somatic Symptom Disorder cohort (Creed et al., 2011).

9.13. Conclusions

It is apparent from the study that the reconfiguration of services to meet the health needs of persistent physical symptom sufferers, along with others coping with long-term conditions within the local population (DH, 2011b), is still in the early stages of development. The process and findings of this realist service evaluation of engagement with persistent physical symptoms, not yet found linked to organic pathology, has developed a depth and breadth of knowledge that enhances the findings of previous researchers. Common factors that are shared by effective therapy interventions and by sufferers of PPS are revealed in the

generally, underexplored complexities of real-world clinical practice. Thus, the reflexive insider-Realist Service Evaluation (ri-RSE) design, which is based on realist principles has provided an ethical and bias-reduced means of developing 'hard to reach' Practice-Based Evidence. This has responded to research recommendations for the study of the process of engagement with PPS in practice (Deary et al., 2007).

The systematic abductive analysis and application of the reflexive function on the data facilitated the discovery of a means of disabling the impact of the PPS. The enhanced theoretical underpinning can be understood by therapists from different therapy-modality training, particularly short-term Psychodynamic and Cognitive-Behavioural, but applicable also to Person-Centred, Experiential Therapists, Mindfulness (Fjorback et al., 2011; Fjorback, 2012), Acceptance and Commitment and Clinical Psychology trainings.

As the particular protective survival mechanisms were positively appreciated and addressed through the process of personal goal development for PPS, the concept of a self-perpetuating cycle of physical symptoms maintenance outlined by Deary et al., (2007) was found supported. The call to identify principles of process for disabling the perpetuating mechanisms by CPPs has been answered in this instance, for non-SSD PPS, through the underpinning ri-RSE methodology and its developed methods. The evaluation findings offer a generic cross-modality pathway towards recovery to the Deary enhanced CBT model of PPS autopoesis.

Despite the limitations, the study observes that this realist evaluation method (ri-RSE) has produced complex and hard to reach, much needed findings on the contextualised lived experience of how the perpetuating mechanisms of non-SSD, PPS can be disabled. It gives an indication of the resources and attitudes required to do so in a real-world non-acute healthcare setting. Having seriously addressed the ethical application of the ri-RSE throughout, these realist evaluation findings cross the

professional and personal, physical and mental health divide, thus providing an integration of principles for teaching, training and action.

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Appendices

Appendix I: Client Feedback Survey (CFS)

CLIENT FEEDBACK SURVEY

Please can you find the time to complete this questionnaire so that we can assess and seek to improve our service?

1. Please state:

Male / Female *(Please circle)* Age Group: 16-25 26-40 41-64 65+ *(Please circle)*

First half of your post code only, e.g. **MK40** or **LU1**: ☐☐☐☐

Ethnic Group: Do you consider yourself as: *(Please tick one box)*

☐ White British	☐ Black Caribbean	☐ Indian
☐ White Irish	☐ Black African	☐ Pakistani
☐ Other White	☐ Chinese	☐ Bangladeshi

Other ethnic group – please write here: ……

Please circle the answers for the following questions, or answer in your own words as required. There are no right and wrong answers to these questions:

2 Who referred you to see the Psychosexual Counsellor?

Mental Health Team
GP
Nurse
Hospital Consultant
Yourself
Other (*please specify)*:

……..

If you chose to opt-in to the service for some appointments, please go to Question 4 to complete the remaining questions.

3 If you did not return your opt-in form or attend your first appointment, please specify why you did not take up psychosexual counselling. *(Please circle the reasons that apply to you)*

Unsuitable location/venue
Inconvenient times

Waiting time was too long

I felt too embarrassed

I thought it would not work

My problem got better

Other *(Please specify)*

……

If you did not opt-in to the service, please go to Questions 11c, 11d and 11e. Please return the form in the prepaid envelope to the address at the end of the questionnaire. Your reply is important to us. Otherwise, if you attended, please continue

4 a) Where were you seen for your appointments? *(Please circle your answers)*

USC

WL

b) Were you happy with the location? YES / NO

If 'NO', please explain why it was unsatisfactory:

c) Was the room/environment in which you were seen satisfactory? YES / NO

If 'NO' please explain why it was not satisfactory:

d) How long were you in therapy? ……. months

How many sessions did you attend? …….sessions

		No problem						**Severe**
5 a)	How would you rate the trouble, worry or distress your problem(s) caused you when you ***first*** came to our clinic?	1	2	3	4	5	6	7
b)	How would you rate the trouble, worry or distress your problem(s) cause you ***now***?	1	2	3	4	5	6	7
		Very dissatisfied						**Very satisfied**
6	**Problem improvement**							
	How satisfied are you with your ability to handle the problem(s) that brought you to therapy?	1	2	3	4	5	6	7

7 **How satisfied are you with your Therapists(s)**

in relation to:	**Very dissatisfied**						**Very satisfied**
Understanding your problem(s)	1	2	3	4	5	6	7
Caring and warmth	1	2	3	4	5	6	7
Respect for your opinions and feeling	1	2	3	4	5	6	7
Knowledge in the special area of sexuality	1	2	3	4	5	6	7
Flexibility with appointments	1	2	3	4	5	6	7
Promptness	1	2	3	4	5	6	7

	Very dissatisfied						**Very satisfied**
8 **How satisfied are you with the the Administrative services?**	1	2	3	4	5	6	7

Please comment:

9 **Why did you stop seeing the Psychosexual Counsellor?**

(Please tick one or more answers)

My sexual concern lessened/or got better

We agreed to end the counselling

The agreed contract came to an end

I decided to ask to end the counselling

I stopped going because

……

10 a) **Did you feel you could come back to the psychosexual counsellor if you needed to?** **YES / NO / UNSURE**

b) **Did you feel the service respected your privacy and** **YES / NO / UNSURE**

If 'NO', please comment:

	Very dissatisfied						**Very satisfied**
11 a) **Your overall satisfaction with the service**:	1	2	3	4	5	6	7

b) Would you recommend our service?

If a friend or relative were to need similar care/treatment

(Please tick one box to answer)

Extremely likely	**Likely**	**Neither likely nor unlikely**	**Unlikely**	**Extremely unlikely**	**Don't know**

c) Please tell us one thing we did well:

d) Please tell us one thing we could do better to improve our service:

Thank you for your time in completing this questionnaire.

Please return your form in the prepaid envelope to:

.....

COMMENTS/COMPLIMENTS/COMPLAINTS

Please do not hesitate to get back in touch with our PALS team if you have any further compliments or compalints during office hours: Monday – Friday 9.00 am – 5.00 pm

PALS & Public Engagement Co-ordinator: Freephone: …

Appendix 2: Operational definitions

1. **Bodily Distress Syndrome** (List in alphabetical order)

Table 1): Diagnostic criteria for Bodily Distress Syndrome (BDS) cited by Creed et al. (2011) after Fink et al. 2007

Yes	No	Symptom Groups
		≥3 cardio-pulmonary/autonomic arousal *Palpitations, heart-pounding, precordial discomfort, breathlessness without exertion, hyperventilation, hot or cold sweats, dry mouth, churning in stomach/'butterflies', flushing or blushing*
		≥3 gastro-intestinal arousal *Abdominal pains, frequent loose bowel movements, feeling bloated/full of gas/distended, regurgitations, constipation, diarrhoea, nausea, vomiting, burning sensation in chest or epigastrium*
		≥3 musculoskeletal tension *Pains in arms or legs, muscular aches or pains, pains in the joints, feelings of paresis or localized weakness, back ache or pain moving from one place to another, unpleasant numbness or tingling sensations*
		≥3 general symptoms *Concentration difficulties, impairment of memory, excessive fatigue, headache, dizziness*
		≥4 symptoms of the above groups

The term Bodily Distress Syndrome (BDS) is argued as making possible a diagnosis of a group:

a) not suffering with BDS

b) to a single-organ type, with symptoms mainly from one organ system found as 25.3% prevalence

c) to those with a severe multi-organ type of bodily distress found in the study as 3.3% prevalence.

The authors Creed et al., (2011) champion the use of BDS as opposed to Complex Somatic Symptom Disorder (CSSD), suggesting that BDS is simpler to use for diagnosis in Primary Care, concluding that the BDS definition identifies, 'patients in need of intensified care' (p.58) by their symptom patterns and exclusion of differential diagnosis. It was of note that the authors also imply to the reader that the severest cases only, justify access to 'intensified care', suggesting that this care be given by resourced specialist liaison psychiatry teams.

2. **Brief Focused Exploratory Therapy**-(BFET) this term applies to the proposed intervention by J Penman, used as a term for the life of this project. It is devised from the foundational work of psychoanalyst Michael Balint (1957), Malan (1963), Main (1989), Draper (1982), Skrine (1987) and Wells (Ed, 2000) and is aligned to a psychodynamic interpersonal therapy as outlined by Guthrie (2004). The model is used in the training of doctors and nurses through the Institute of Psychosexual Medicine (Skrine, 1997), and the Association of Psychosexual Nursing in day-to-day practice (Clifford, 2000). It includes, if indicated, a psychotherapeutic physical examination but only on informed consent and by a qualified and experienced Healthcare Professional. The physical examination will not be used in the cases studied so that generic counsellors and psychotherapists can relate to the findings. De Shazer & Berg's solution focus and occasional behavioural exercises are adapted to the individual's needs (Hawton, 1985). At the heart of BFET lies a psychodynamic emphasis (see Shedler 2010 below) which equates to a brief form of the psychodynamic interpersonal therapy, manualised for training and the treatment of PPS (Creed et al., 2003; Guthrie et al., 2004) in primary care.

3. **Cognitive-Behavioural Therapy (CBT)**. Behavioural Therapy was used in the earlier half of the 20th Century as a short-term alternative to psychoanalysis. At the time, the new cognitive science was developed by psychiatrist Beck to create the Cognitive-Behavioural model which became more effective. Taken from the definition given by the National Association of Cognitive Behavioural Therapists http://www.nacbt.org/whatiscbt.htm CBT is based on the Cognitive Model of Emotional Response. Cognitive-behavioral therapy is based on the idea that *thoughts* cause feelings and behaviours, not external things, like people, situations, and events. It is suggested that if it is possible to change thoughts, then feelings and changed actions follow (site accessed 8th March 2013).

In the project's data analysis phase, some elements of changed cognition may be linked to change in body symptoms, but the pro-active use of feelings within the study is understood at this stage as facilitated by in large, the use of psychodynamic principles.

2. **Functional Somatic Syndromes** (FSS) came within Axis III of the DSM-IV-TR definition and included diagnostic terms such as Fibromyalgia, Irritable Bowel Syndrome, Functional Dyspepsia, Irritable Bladder, Atypical Chest Pain, Chronic Back or Pelvic Pain, Atypical Facial Pain, Multiple Chemical Sensitivity Syndrome, Hyperventilation etc. for which as yet, medicine has no clear causal explanation (RC Psych., 2009). FSS are no longer identified by DSM-5 as bearing a relationship to Somatic Symptom Disorder.

3. Participant Inclusions

- Aged over 18 and up to 64 as the recognized definition of 'adult' in the commonly used search engines such as MEDLINE, PsyINFO
- Referred to the specified Primary/Community Care Psychosexual Counseling Clinic by a registered healthcare professional
- Organic cause of the persistent sexual symptoms, if indicated, investigated by GP or Hospital Consultant prior to referral
- A minimum of a six-month history of sexual symptoms not wholly explained by medical condition falling within the DSM 5 criteria for sexual symptoms 302.70-302.76 (APA, 2013)

4. Participant Exclusions

- Significant bereavement in the preceding six months
- Severe Eating Disorder
- Developmental or Acquired Learning Challenges
- Recent Psychotic Episode or suicide attempt within the preceding year
- Substance Addiction
- History of being unable to form satisfactory relationships
- Medication induced sexual dysfunction
- Any individual requiring an interpreter for communication with the therapist

5. Persistent Medically Unexplained Symptoms (PMUS) inclusions and exclusions

rationale for use of the term:

The author's patient group shows the phenomenon of PPS, but does not fit clearly either into the newly proposed DSM-V category of 'Complex somatic symptom disorder' (CSSD) with excessive rumination over the symptoms (Table 2 below) nor necessarily into 'Bodily Distress Disorder' (Table 1 above). The word 'persistent' (P), meaning a duration of bothersome symptoms longer than 6 months, is added to the term 'Medically unexplained symptoms' (MUS) used in the literature. Thus PMUS for the purpose of this study is expressed within the definition, **'Undifferentiated somatoform disorder'*** of the DSM-IV

Axis I, code 300.82 or in ICD-10 code F45.1, and if needs be by the definition of a Functional Somatic Syndrome (previously DSM-IV, Axis III), to capture the possibility should it arise, of an added history such as fibromyalgia or irritable bowel syndrome within the study participants. The **persistent sexual symptom** (PSS) is taken on for use in this study: 'not fully explained by medical condition' is the reason for the majority of the patient referrals to the clinic of the study.

6. **Persistent Sexual Symptoms (PSS)**- the project includes sexual symptoms not due to or not wholly explained by a medical condition from the DSM-5 and ICD-10, Section V, in block F52 in brackets:

302.72 (F52.21) Male Erectile Disorder
302.73 (F52.31) Female Orgasmic Disorder
302.74 (52.32) Delayed Ejaculation
302.75 (F52.4) Early Ejaculation
302.72 (F52.22) Female Sexual Interest/Arousal Disorder
302.71 (F52.0) Male Hypoactive Sexual Desire Disorder
302.76 (F52.6) Genito-Pelvic Pain/Penetration Disorder
302.70 (52.9) Unspecified Sexual Dysfunction

7. **Primary (Health) Care/Community Care**-this study uses the term **Primary /Community Care** as it does not involve hospital in-patient stays and is interpreted for the study from MEDLINE scope note: 'Care which provides integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community.' (JAMA 1995; 273(3) pp.192.) This applies to the close liaison of the clinic with referring GPs in the on-going care of the patient.

8. **Psychodynamic Principles**- The term 'psychodynamic principles' is selected as a term for the project as short-term psychodynamic psychotherapy (STPP) is traditionally considered to be between 12-20 weekly sessions. The brief focused exploratory therapy used as the intervention for the project sees individuals for Assessment plus six follow-up sessions delivered on a 3-4 weekly basis, using these principles to get to the heart of the meaning of PMUS for the individual.
Shedler (2010)$^{+}$ identifies seven core techniques representing a broad psychodynamic focus:
1) Focus on feelings and expression of emotion
2) Exploration of attempts to avoid distressing thoughts and feelings
3) Identifying recurring themes and patterns

4) Discussion of past developmental experiences and how these shed light on current coping
5) Focus in interpersonal relations in terms of understanding patterns of meeting, or not meeting, emotional needs
6) Focus on the therapy relationship as a live example of patterns of relating
7) Given the opportunity to explore desires, fears, and fantasies

A key element of psychodynamic counselling is that understanding is achieved within the counselling relationship not by conscious control of the material but through a trust in the containment of the setting and the process, and by paying constant focused attention to the patient/therapist relationship. The focus is not reliant on the distraction of ‘knowing’ or ‘getting it right’. This perspective will be used in the therapy along with other elements of the author-described BFET above, tailored to the individual.

PTO for Somtatic Symptom Disorder (Table 2)

9. Somatic Symptom Disorder

Table 2): Diagnostic criteria proposed for DSM-5 'Complex Somatic Symptom Disorder' (CSSD) to be published May 2013, after Creed, Henningsen and Fink (Eds. 2011, p.55.)

To meet criteria for CSSD, criteria A,B & C are necessary	*Symptom count*
A. Somatic symptoms	*One or more somatic symptoms that are distressing and/or result in significant disruption in daily life*
B. Excessive thoughts, feelings and behaviours related to these somatic symptoms or associated health concerns	*At least two of the following are required to meet this criterion:* *(1) High level of health related anxiety* *(2) Disproportionate and persistent concerns about the medical seriousness of one's symptoms* *(3) Excessive time and energy devoted to these symptoms or health concerns*
C. Chronicity	*Although any one symptom may not be continuously present, the state of being symptomatic is chronic (at least six months)*

Undifferentiated Somatoform Disorder*-see above

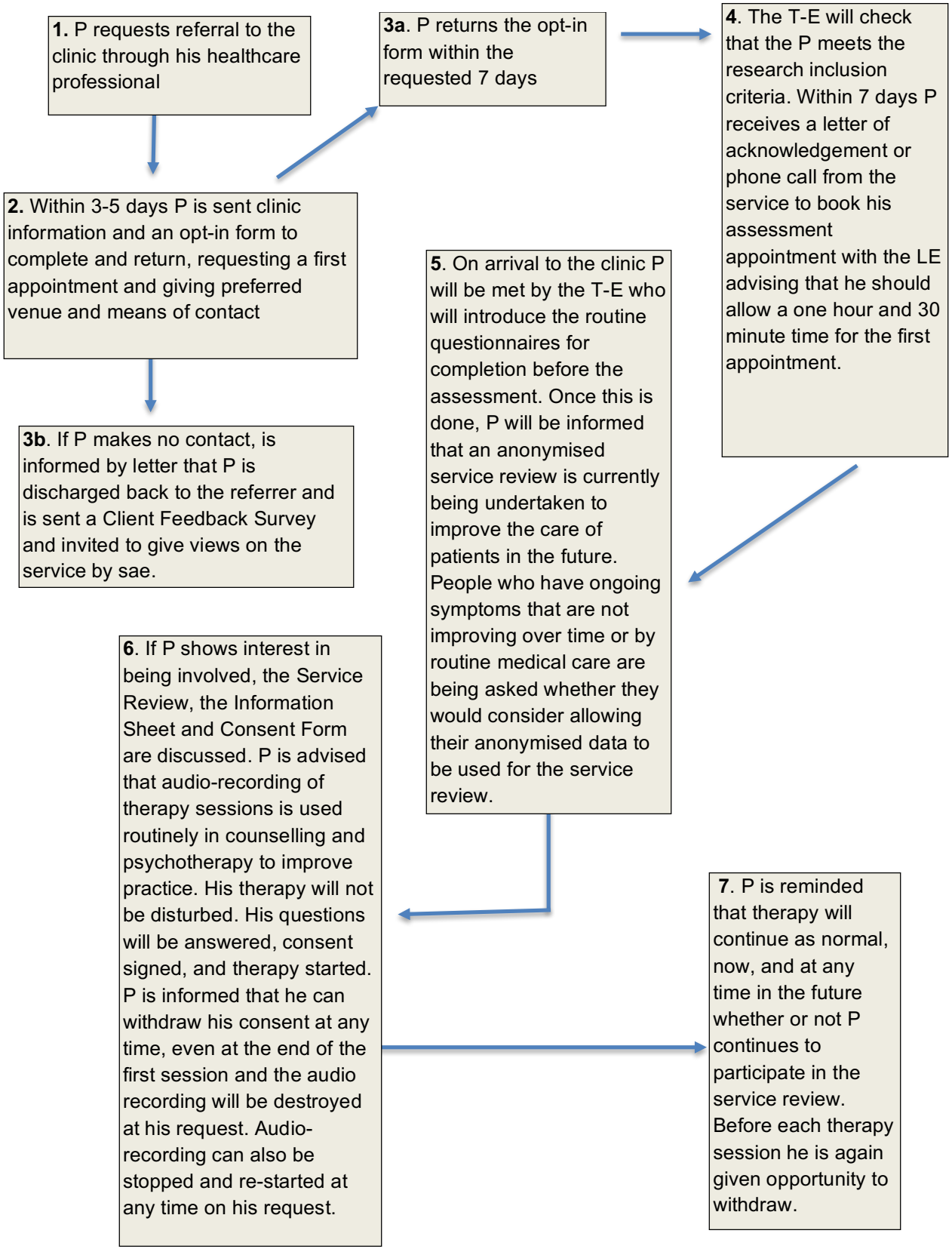
Appendix 3: Participant experience protocols

a) Stage 1 Participant Experience: Protocol for taking informed consent;
b) Stage 2: Participant Experience: during and after therapy

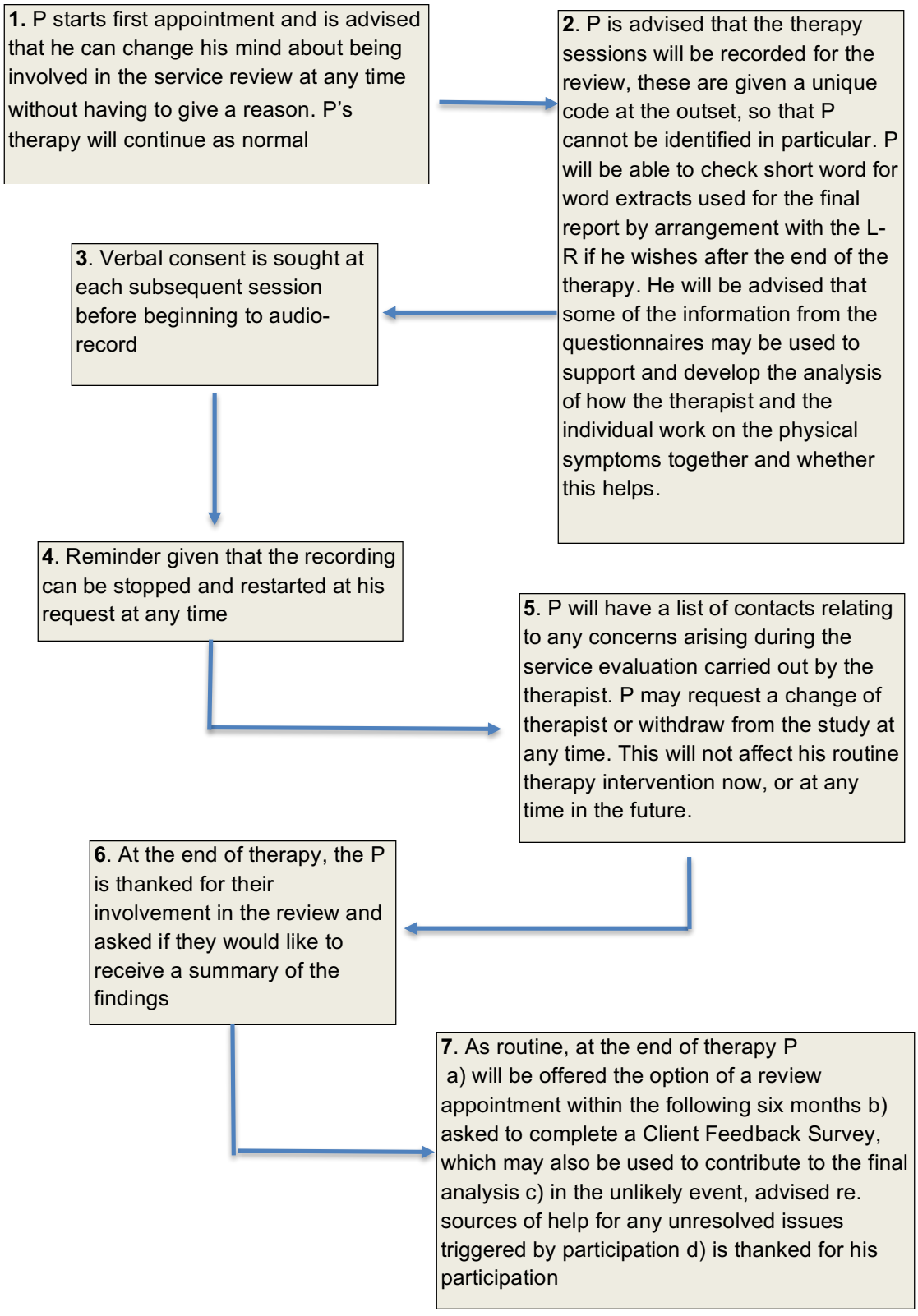
See following sheet

Participant selection is during a 2 month period of all referrals to the clinic who meet the inclusion criteria: ‘P’ denotes ‘Person’, inclusive of any gender, T-E denotes the Therapist Evaluator

Stage 1 Protocol for taking informed consent



Stage 2. Participant Experience-Pathway during and after therapy: minimising therapy disruption **(inimising therapy disruption, inclusive of any gender; T-E'-EimisinTherapist-Evaluator)**



Appendix 4: Data Collection

Routine ordinal measures and references

The demographics of the participants at the time of Assessment will be collected using the **CORE-Therapy Assessment Form** by the therapist before the audio recording of the Assessment session begins to assist any comparison required across the cases.

In order to keep a structured written and reflective record of the therapy sessions, extra to routine clinical case notes, the work of a group of clinician-researchers found at www.experientialresearchers.org recommends the use of the **Experiential Session Form** devised by Elliott (2002) and with his permission by email, is shortened to the use of sections I-III. This covers a) therapist observations and reflections, b) overall session ratings as helpful or hindering using a Likert Scale and c) identification of the individual's in therapy mode of engagement. This will be used as contextualising background material only and for reflexive purposes.

Good outcome therapy is now known overall to be due more to client factors (70%) than to any other (Cooper, 2012). These will be observed during the study. However goal consensus and collaboration, have been shown as demonstrably important to quality outcomes (Norcross, 2002) and will be measured by the **Goal Assessment Form**, **GAF** developed by the University of Strathclyde and now used within the routine therapy intervention (www.strath.ac.uk/humanities/counsellingunit/pluralistic/). Once the goals are defined the GAF will be completed and discussed as a part of subsequent sessions. The measure is usually taken twice during the course of therapy.

The Patient-Health Questionnaire, PHQ-15 tested by Korber et al., (2011) has been found suitable as a simple measure to pick up any medically unexplained somatic, including sexual symptoms and their level of severity for the individual in Primary Care. This will be completed as a routine part of the therapy immediately before Assessment, and again before the session at mid and end of therapy to observe for symptom recognition and change.

An assessment of well-being will be gathered routinely at the same time as the PHQ-15, and again will offer context in relation to self-perceived well-being through

the positive language of the **Warwick and Edinburgh Mental Well-Being Measure, WEMWBS** (Stewart-Brown et al., 2009) during the therapy exploration. This measure was selected as the participant cohort being studied, do not necessarily look for help with mental health problems at the time of their presentation to the clinic. This will be completed routinely at the same time as the PHQ-15, three times, adding context to the analytic process.

At the end of therapy, all patients are given the opportunity for feedback. A **Client Feedback Survey** is given either at the last therapy session or sent by post to be completed in privacy and returned within the following 3-4 days. The format of the feedback has been continuously developed over the last 10 years (Penman, 2009). In 2013 the form was further adapted from the Porterbrook Clinic, Sheffield patient end of therapy questionnaire. Here a Likert Scale 1-7 assesses following therapy, how confident the patient feels in managing their issues in the future

Appendix 5: Questionnaires

See Appendix 4 for measures references and use

The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)

Below are some statements about feelings and thoughts. Please tick the box that best decribes your experience of each over the last 2 weeks

STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Patient Health Questionnaire (PHQ-15)

A 15 item Somatic Symptom Severity Scale

During the past four weeks, how much have you been bothered by any of the following problems	**Not bothered at all**	**Bothered a little**	**Bothered a lot**
Stomach pain			
Back pain			
Pain in your arms or legs or other joints			
Menstrual cramps or other problems with your periods (women only)			
Headaches			
Chest Pain			
Dizziness			
Fainting spells			
Feeling your heart pound or race			
Shortness of breath			
Pain or problems during sexual intercourse			
Constipation, loose bowels, or diarrhoea			
Nausea, gas, or indigestion			
Feeling tired, or having low energy			
Trouble sleeping			

Score:

Not bothered at all = 0
Bothered a little = 1
Bothered a lot = 2
0 – 4 = no somatisation disorder
5 – 9 = mild somatisation disorder
10 – 14 = moderate somatisation disorder
15 + = severe somatisation disorder

The PHQ-15 is intended to supplement clinical acumen and experience for individual patient

Goal Assessment Form (GAF)

Goal 1:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7

Goal 2:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7

Goal 3:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7

Goal 4:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7

Goal 5:						
Not at all achieved						Completely achieved
1	2	3	4	5	6	7

EXPERIENTIAL THERAPY SESSION FORM CESP-II (8/02, ©R. Elliott)

CASE_____ SESSION_____ DATE_____
THERAPIST_____

I. Process Notes

1. Brief summary of main episodes and events of session:

2. Unusual Within-therapy Events (e.g., late, interruptions, challenges, out-of-mode)

3. Important Extra-therapy Events (e.g., relationships, work, injury/illness, changes in medication, self-help efforts)

4. Ideas for next time (from self & supervision):

II. Overall Session Ratings:

1. Please rate how helpful or hindering to your client you think this session was overall. (Check one answer only) THIS SESSION WAS:	1. Extremely hindering ____ 2. Greatly hindering ____ 3. Moderately hindering ____ 4. Slightly hindering ____ 5. Neither helpful nor hindering; neutral ____ 6. Slightly helpful ____ 7. Moderately helpful ____ 8. Greatly helpful ____ 9. Extremely helpful
2. How do you feel about the session you have just completed with your client?	____ 1. Perfect ____ 2. Excellent ____ 3. Very good ____ 4. Pretty good ____ 5. Fair ____ 6. Pretty poor ____ 7. Very poor
3. How much <u>progress</u> do you feel your client made in dealing with his/her problems in this session?	____ 1. A great deal of progress ____ 2. Considerable progress ____ 3. Moderate progress ____ 4. Some progress ____ 5. A little progress ____ 6. Didn't get anywhere in this session ____ 7. In some ways my problems have gotten worse this session
4. <u>In this session</u> something <u>shifted</u> for my client. S/he saw something differently or experienced something freshly:	____ 1. Not at all ____ 2. Very slightly ____ 3. Slightly ____ 4. Somewhat ____ 5. Moderately ____ 6. Considerably ____ 7. Very much

III. Client Modes of Engagement:

Please rate the extent to which your client was engaging in each of the following modes of engagement during the session:

Absent	Occasional 1 - 5% of responses	Common 10 – 20% of responses	Frequent 25 - 45% of responses	Extensive ≥ 50% of responses
1	**2**	**3**	**4**	**5**

1 2 3 4 5	1. External: Attending to other people, external events; may be specific or general.
1 2 3 4 5	2. Purely conceptual: Formulating things in linguistic or abstract terms without reference to concrete experiencing.
1 2 3 4 5	3. Somatic: Attending to chronic pain or illness signs.
1 2 3 4 5	4. Containing/distancing: Avoiding or holding painful or frightening feelings or experiences at bay.
1 2 3 4 5	5. Internal attending: Turning attention inward to clear feelings, thoughts, images or bodily sensations.
1 2 3 4 5	6. Experiential search: Examining unclear internal experiences with curiosity; staying with vague or ambiguous experiencing.
1 2 3 4 5	7. Active expression: Displaying or enacting strong, vivid, specific reactions.
1 2 3 4 5	8. Interpersonal contact: Trusting, opening up to therapist.
1 2 3 4 5	9. Self-reflection: Standing back from experience in order to develop meaning perspective.
1 2 3 4 5	10. Emergent action: Applying results of experiential work to problem-solving and productive action.

Appendix 6: Anonymisation and data protection

***Data storage**:* Once the consent form is signed:

- any documentation relating to the participant will have their name replaced by an evaluation code
- the Therapist-Evaluator (T-E) will be the only one with access to the details of name linked with their evaluation code in order to protect individual confidentiality
- this information will be kept separately and securely from the evaluation data under locked conditions to which only the T-E has access
- this link will be destroyed using an NHS shredding facility once the academic award has been achieved
- audio-recordings of therapy will also be safely destroyed once the educational qualification has been achieved
- content of anonymised recordings will be transcribed under NHS Data Protection agreement and transferred back to the T-E, to a password protected laptop
- selections of the anonymised data transcripts will be shared, only by the permission of the T-E, for analytic consultation and academic supervision
- those members who check any raw anonymised data as part of the analytic process, at the permission of the T-E, will have no means to link the data to the participants

Publication and dissemination of findings:

- The participants are offered the opportunity to check selections of session audio-transcripts which may be used for publication and teaching for personally identifiable material
- Any identifying material will be adjusted by agreement, by the T-E and participant if required
- Consent for the publication of extracts of anonymised data is sought at the outset for educational and training purposes only
- The participant may request a summary of the findings

Appendix 7: Participant information paperwork

Cambridgeshire Community Services NHS
NHS Trust

PS Counselling: Service Review

Information Sheet

Lead Reviewer: Mrs Jean Penman, Specialist Counsellor

[redacted]

Thank you for taking time to consider participating in this service review. This document outlines the purpose of the review and what your involvement will entail. Please do not hesitate to ask at any time if you need further explanation or information.

The service review aims to develop a deeper understanding of how the individual and therapist work together on persistent physical symptoms, particularly in the early stages of therapy. The review is intended to explore how this affects your sense of well-being, whether it brings about any physical changes and how it impacts on your personal goals for therapy.

The service review uses routine data collection from the therapy sessions to develop knowledge of a particular aspect of therapy or service provision.

Persistent Physical Symptoms (PPS): These are represented by a change to someone's body and how it works that is not fully explained by any currently known disease. These physical changes have not improved over time nor have they got better with routine medical care. PPS are a common reason for consulting a GP to find out what is wrong. Persistent physical symptoms include changes in sexual function and other physical symptoms such as bowel and tummy problems, breathlessness, backache, headaches, difficulty sleeping and many others….

1. Why is this review taking place?

We would like to find out more about how the individual and the therapist address physical conditions in therapy that are not getting better over time or through routine medical care. To do this, we need to be able to a) analyse thoroughly the content of a certain number of therapy sessions in order to understand this better and b) examine whether the routine questionnaires used in therapy can also develop understanding. The way we do this

evaluation is to audio-record the therapy sessions and anonymise all data before analysis to ensure confidentiality is protected.

Recording the therapy sessions with patient consent and pulling together data from routine questionnaires is normal practice for improving the quality of and learning from psychotherapy and counselling interventions.

2. Why have I been invited to participate in the review?

You have been asked because you have been referred to the PS Counselling Service provided by Cambridgeshire Community Services NHS Trust and fall into the criteria for invitation with your particular symptoms, along with other people recently referred. To increase our understanding, we need to analyse in depth, in particular, the early sessions of therapy and to examine the measured outcomes before, during and at the end of therapy.

3. What are the possible benefits of taking part?

There will be no direct benefit from participating in this study. However, the study will help to develop knowledge about *how* the individual and the therapist work on persistent physical symptoms and what circumstances facilitate change. You will be supporting this study with your data. This will be used in anonymised form to develop much needed knowledge. The review findings will contribute to the Lead Reviewer's Professional Doctorate in Health Related Studies, undertaken with the Institute of Health Research, University of Bedfordshire. The service review is approved and sponsored by Cambridgeshire Community Services.

4. What will happen if I agree?

Your therapy will continue as normal including completion of our routine questionnaires. The only difference is that you will be asked for your consent to have the therapy sessions recorded anonymously from part way through the first assessment session to the sixth follow-up session. This will be done in an unobtrusive way so that it does not distract, destroy relationships or reduce the benefits of the therapy session.

5. Will my participation in the study be kept confidential?

- All employees of CCS, regardless of their status and role, will have signed a confidentiality agreement and that any breach, however minor, of that code of conduct is a disciplinary offence
- There will be no-one else present in the therapy sessions, apart from your usual therapist
- Your therapy session recordings will be identified by a review code only
- It will not be possible for anyone else to link your name to the data
- The therapy will be recorded unobtrusively by USB device to ensure the sessions are not disturbed

- The anonymised recording will be transcribed by a member of the review team into a confidential computerised database which can only be accessed by authorised personnel connected with the service review.
- The digital recordings and any transcriptions will be kept securely separate from the clinical notes so that, again, no-one apart from the Lead Reviewer will be able to link your name to the data
- The recordings will be erased at the completion of the review

6. What will happen to the outcomes of the review and how will the results be disseminated?

- The review outcomes may be illustrated by short extracts of selected verbatim (word for word) material
- The Lead Reviewer will ensure that you cannot be identified from any word for word extracts
- You will also be invited, if you wish, to double-check with the Lead Reviewer, to check any verbatim extracts taken from your data to reassure yourself that readers cannot identify you from that particular extract
- It is planned that the anonymised findings will be published in reputable journals/books
- The anonymised results will be presented at professional conferences; this is for the purposes of educational, service commissioning and service development

7. Do I have to take part?

- As an NHS service user you have already agreed to your anonymised data being used by Cambridgeshire Community Services (CCS) for service monitoring
- You are under no obligation to consent to your data collection being used for this particular service review

8. Can I withdraw from the review if I change my mind?

- If you do decide to take part, you are still free to withdraw your consent to the use of your data for this service review at any time and without having to give a reason (see the Consent Form)
- Whether you are involved or not, or you withdraw at any time, will not affect your treatment within this or any other services provided by the National Health Service (NHS), CCS, that you may need to access now or in the future

9. What are the possible disadvantages and risks of taking part?

- You may feel uncomfortable about publication or presentation of the review - Please see points 5 and 6 for reassurance

- As stated above, you will be offered the opportunity, if you would like it, to review any word for word extracts selected from your data to be reassured that you will not be identified through publication

10. What should I do if I, or my therapist have concerns at any time?

If you have a concern about any part of this service review

- ask questions of your therapist, Jean Penman, until you feel comfortable
- contact the Service Manager, W.L. Health Centre, ----------Tel: ----------
- if serious risk of harm to self or others is disclosed, or your therapist is concerned that your therapy is being affected by participation, for your protection and safety your participation in the study will cease

If your questions have not been answered to your satisfaction and you wish to make a complaint regarding the service you are receiving, you should not hesitate to contact the Patient Liaison Service, as is normally suggested, on Freephone 0800 0132511 or email:

Thank you for taking time to think about participating in this service evaluation.

Jean Penman, Lead Reviewer
U.S. Clinic, --------. Tel: -------

Consent and consent withdrawal

Cambridgeshire Community Services NHS
NHS Trust

Consent to use of therapy data for service review

Name:

Through this service review, your anonymised data will help to develop a deeper knowledge of how the patient and therapist work on persistent physical symptoms in therapy.

Lead Reviewer:

Mrs --------- Address: Clinic:-------- Tel: --------

Service Manager:

Mrs --------- Address: Clinic:-------- Tel: --------

Once you have had all your questions answered satisfactorily, please initial each point below if you agree:

1. I have understood the Service Review Information Sheet which is attached to this form and have had the opportunity to ask questions which have been answered to my satisfaction. ☐
2. I understand that I am free to withdraw my consent to the use of any of my data for this service review without having to give a reason and that withdrawal will not affect my on-going therapy or any therapy I need in the future. ☐
3. Data protection: I agree to the Trust processing personal data which I have supplied. I agree to the processing of such anonymised data for any purposes connected with the service review as outlined to me. ☐
4. I have been informed that the confidentiality of the information I provide will be safeguarded. ☐
5. I agree to my therapy sessions being audio-recorded anonymously. ☐
6. I agree that the anonymised data can be analysed by the authorised study team to develop a deeper understanding of how a patient and therapist engage with persistent physical symptoms during therapy. ☐
7. I agree that knowledge gained may be passed on through presentations, teaching and educational publications and I agree to the inclusion of personally non-identifiable verbatim extracts to illustrate the findings. ☐
8. If serious risk of harm to self or others is disclosed, I agree that my personal data will be withdrawn from the study ☐
9. I have been provided with a copy of this form and the Service Review ☐

Information Sheet to keep

I have read and consent to the above

Name of individual:

(print)……

Signed: …… Date: ……

Name of person taking consent:

(print)……

Signed: ……Date:

You will be given a copy of this form to keep

Cont.

Withdrawing Consent

If you wish to withdraw your consent to recording and analysis of your anonymised data, please complete the form below and return to the Lead Reviewer named above or telephone ---------- for further advice from the Service Manager. Your on-going therapy will not be affected by the withdrawal of your consent at any time and you do not have to give a reason for withdrawal.

Title of the service review: 'Developing a deeper understanding of how, and to what effect, the patient and therapist engage with persistent physical symptoms in therapy'.

I WISH TO WITHDRAW MY CONSENT TO RECORDING AND TO ANY ANALYSIS OF THE ANONYMISED TRANSCRIPTS OR OTHER DATA LINKED TO MY THERAPY FOR THE PURPOSES OF THIS SERVICE REVIEW.

Print Name: ……..

Signed: ……..

Date:……

Appendix 8: Supporting letter of approval

Cambridgeshire Community Services NHS
NHS Trust

Unit 3
Meadow Lane
St Ives
Cambridgeshire
PE27 3LS

8th April 2014

Psychosexual Counselling Clinical Lead
[redacted]
Cambridgeshire Community Services
[redacted]

Dear Jean.

Re: **Exploring the engagement with persistent physical symptoms in the early stages of therapy, within a Community NHS Trust**

PhD taught Student Research Project

Your project proposal has been reviewed by Dr David Vickers, Medical Director and has given permission for your evaluation to take place. Your line manager is aware that this project is being undertaken and is supporting the project. Contact within the Trust: Jo Radnor, Manager.

The project must follow the agreed protocol which you submitted and be conducted in accordance with Trust policy and procedures in particular in regard to data protection, health & safety and information governance standards. If your project changes in any way from the methodology stated on the submitted major project form then you must stop the project immediately and contact the Senior Research Fellow on the above number to discuss. Major changes may necessitate re-submission to the Medical Director before the project can re-commence. As this project is considered a service evaluation then full ethics permission via IRAS is not required.

You may be required to complete monitoring information during the course of the project, as requested by the Cambridgeshire Community Services NHS Trust Research and Evaluation Governance Panel. Upon completing the project you **will** submit a project

summary which includes a list of recommendations and actions to the Senior Research Fellow at CCS NHST.

Should any service or procedural issues be flagged up during the evaluation, Cambridgeshire Community Services NHS Trust Research and Evaluation Governance Panel should be contacted immediately to ensure that these addressed by the relevant line managers.

Please contact the Senior Research Fellow, Paula Waddingham, in the first instance should you have any queries.

Yours sincerely,

Dr David Vickers
Medical Director/Chair of Cambridgeshire Community Services NHS Trust Research and Governance Panel CCS NHST

Appendix 9: Service Evaluation: evidence for exclusion from the IRAS

Research or audit/service evaluation: IRAS advice sheet

Where a project is not classified as research, all potential applications in IRAS are disabled except those to the National Information Governance Board (NIGB; see note below). Applications to other bodies are required only where a project is considered to be research.

The Research Governance Frameworks for Health and Social Care set out the responsibilities and standards that apply to work managed within the formal research context. For the purposes of Research Governance, 'research' means the attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods. Although some research projects include evaluation, where a project is considered to be **solely** audit or service/therapy evaluation, it will not be managed as research within the NHS or social care. **Such projects do not require ethical review by a NHS or Social Care Research Ethics Committee or management permission through the NHS R&D office.** There is no need to submit applications in IRAS either to the NHS REC or R&D office.

Differentiating research, audit and service evaluation

The Health Research Authority (HRA) has prepared some simple guidance for researchers in the form of a decision tool, which is available at http://www.hra.nhs.uk/resources/before-you-apply/is-it-research/. The NHS R&D Forum has published more detailed guidance aimed primarily at NHS R&D offices, which is available at http://www.rdforum.nhs.uk/docs/categorising_projects_guidance.doc.

The decision tool is for use by applicants and R&D offices in assessing whether or not a project should be classified and managed as research. If in doubt, you may consult the Chair of your local NHS REC or your R&D office, or email the HRA Queries Line at hra.queries@nhs.net.

Additional guidance on the characteristics of research in the social care setting is available in the Research Governance Framework Resource Pack for social care

available at http://www.ssrg.org.uk/governance/index.asp. You can also seek advice from the Social Care REC coordinator at screc@scie.org.uk

If after discussion the project is considered to be research, reply "Yes" to sieve question 1 and proceed with applications to a NHS REC and R&D office.

If the project is solely audit or service evaluation, or some other type of non-research activity such as case study, system/equipment testing or satisfaction survey, you should check with the NHS clinical governance office or local authority what other review arrangements or sources of advice apply to the project. For example, there may be standard guidelines on the conduct of clinical audit. The Caldicott Guardian of Local Authority Information Governance Lead will be a source of advice on the use of patient or service user data.

National Information Governance Board for Health and Social Care (NIGB) and Confidentiality Advisory Group (CAG)

If you are conducting an audit, service evaluation or other non-research activity with a medical purpose and the project will involve use of identifiable patient data without explicit consent, you may need to apply for support under Section 251 of the NHS Act 2006. Please select NIGB under Question 4 below in the sieve and continue with the application. Please note that on 1 April 2013, the responsibility for review under Section 251 transferred from the NIGB to the HRA. The HRA has established the Confidentiality Advisory Group (CAG) to review applications and provide advice to the HRA in respect of this function.

Appendix 10: NHS R&D Forum

NHS
Research and Development Forum

Categorising Research within the Research Governance Framework for Health and Social Care

July 2006

Background

This guidance has been collated by the NHS Research and Development Forum as an aid to researchers and NHS R&D staff in determining what projects should be managed in accordance with the Research Governance Framework in NHS organisations. The guidance has been developed following consultation with researchers, R&D managers, Clinical Effectiveness and Audit staff, and R&D Support Unit staff.

"1.10 Research can be defined as the attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods. This document sets out the responsibilities and standards that apply to work managed within the formal research context. Other documents on quality and governance in the NHS and social care set out standards and systems for assuring the quality of innovative work in non-research contexts."

Research Governance Framework for Health and Social Care, Second edition, 2005
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

It is clear from the above extract from the Framework that although the NHS has a responsibility for assuring the quality of all work undertaken within the service, not all innovative work should be defined and managed as research. The increasing amount of evaluation, practice development, audit and research within the NHS has resulted in a number of grey areas where it is not easy to distinguish research

from other forms of innovative work. Some NHS R&D departments may wish to treat all grey areas as research to avoid the risk of any research not being managed correctly. However, this would result in an unnecessary administrative burden to the people undertaking the work, and an unnecessary management burden and cost to the R&D department. Projects that are not defined as research should therefore be managed within other appropriate systems in the NHS.

Where a proposed project seems difficult to categorise, the aims of the project should be assessed. The project should be designed to match the purpose. Furthermore, the management processes governing the project should be proportionate to the risks and implications of the proposed project.

NHS R&D departments are encouraged to develop appropriate links with other relevant departments such as clinical governance and data protection so that procedures are in place to manage the legal and ethical aspects of all types of projects. There are a wide range of legal requirements that apply specifically to research and it is important that NHS organisations have systems to ensure they meet their legal obligations. The legal requirements relating to confidentiality and consent are most likely to be of relevance in grey areas. Where projects are difficult to categorise, the legal implications should be assessed.

This document is not intended to provide a comprehensive or detailed guide, but to provide sufficient information to enable R&D Managers to make decisions about how to manage projects.

Research

"Research can be defined as the attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods."

Research Governance Framework for Health and Social Care, Second edition, 2005
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

Research generates evidence to refute or support or develop a hypothesis. Research aims to find out what happens if we add or change (manipulate) clinical or service practice in some way, or aims to find out in a systematic way the views/ opinions/ experiences/ understandings of stakeholders. It may also require only observation, without any intervention, and may be prospective or retrospective. It may be qualitative or quantitative in approach. Research is designed so that the results of the research or the theories derived from the research should be generalisable or transferable beyond the sample upon which the research was based.

Research is likely to involve one or more of the following [1]:

- Usually involves well-defined, often strict selection criteria for the sample selected
- Should be protocol-driven, although the design of qualitative research may require sufficient flexibility to respond to discoveries during the research process
- Quantitative research is designed so that it can be replicated. It may not be possible to replicate qualitative research, but it should be possible to form a judgement of the validity of the qualitative research process.
- In quantitative research, the sample size is usually defined by statistical methods. In qualitative research, statistical sample calculations and statistical sampling methods may not be applicable. There should however be a clear rationale for the sampling procedure used.
- Quantitative research usually involves statistical analysis to extrapolate from the sample to a wider population. This includes studies where only simple descriptive statistics such as percentages are appropriate.
- May test a new or additional practice, therapy or drug
- May involve contact with participants
- May involve experiments on human subjects, whether patients, patients as volunteers, or healthy volunteers
- May be invasive
- May involve collecting data from medical records
- May solely involve collecting data from medical records

[1] The use of "may" means that the inclusion of the item listed does not define the work as research. Other types of work include these items and some types of research do not include these items.

- May involve examining tissue or body samples
- May involve extra disturbance or work beyond that required for normal clinical management
- May use interviews or questionnaires
- Participants may be randomised
- Qualitative research uses a variety of methods, e.g. observation, interview, or other information, to describe, understand or interpret a situation or issue
- It is intended to publish and disseminate the results beyond the organisation, generally at conferences or in academic journals.
- The results may change practice if new interventions, tests, etc are shown to be effective

Research that is poorly designed and therefore does not have a clearly defined question or systematic and rigorous methods should not be managed as audit or service evaluation.

Clinical Audit [2]

"Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery."

Principles for Best Practice in Clinical Audit, National Institute for Clinical Excellence, 2002

http://www.nice.org.uk/pdf/BestPracticeClinicalAudit.pdf

and *Standards for Better Health, DH, 2004*

http://www.dh.gov.uk/assetRoot/04/08/66/66/04086666.pdf

Clinical Audit is directly related to assuring services against a standard that has already been set by examining:

1. Whether or not what ought to be happening is happening
2. Whether current practice meets required standards

[2] This section was prepared in consultation with the National Audit and Governance Group and the South East Clinical Effectiveness Network.

3. Whether current practice follows published guidelines
4. Whether clinical practice is applying the knowledge that has been gained through research
5. Whether current evidence is being applied in a given situation

Clinical Audit [3]:

- May or may not involve patient contact but generally does not involve changes to normal clinical management
- Usually involves no more than administration of a questionnaire but can potentially require substantial patient/carer input and carry risks of distress and psychological harm
- Participants are never randomised to different treatments or services. Participants may receive or have received different treatments or services before the clinical audit
- Results are not transferable to other settings
- May use research methodologies e.g. interviews, random sampling, descriptive (not inferential) statistical analysis

Standards of good practice are the basis of measurement not hypotheses and/or theoretical constructs

- Clinical audit outcome is the quality assurance of practice; Clinical research outcome is improved knowledge.

Surveys should be designed in such a manner as to cause minimal possible disruption to patients. Where substantial patient/ carer input is necessary ethical approval may be appropriate. This may be from a clinical or university ethics committee. Issues such as confidentiality, validity, questionnaire design and whether participants might be distressed or harmed by their involvement should be reviewed by the NHS organisation but not necessarily by the R&D Department. Information on confidentiality and consent issues relating to audit is available from the Healthcare Commission http://www.healthcarecommission.org.uk/InformationForServiceProviders/NationalClinicalAudit/fs/en.

Student Research

[3] The use of "may"means that the inclusion of the item listed does not define the work as clinical audit. Other types of work include these items and some types of audit do not include these items.

Student projects should be assessed by the same criteria as above and managed as research, where it is research. Where a student project is not research, the project should not be managed as research. Further guidance on student research is available from the Central Office for Research Ethics Committees (COREC) http://www.corec.org.uk.

Clinical Investigation

Diagnostic tests may be the subject of a research study by a scientist within or outside the NHS. In situations where diagnosis of disease is difficult, NHS staff may request such a diagnostic test, in an attempt to obtain a diagnosis. Where the purpose of requesting the test is to obtain a diagnosis or to determine the appropriate care for a particular patient (or relatives, in the case of genetic disease), the request for the test should not be regarded as research. The person requesting the test does not need to be included in an ethics application and R&D approval from the NHS organisation of the person requesting the test is not required. Where the purpose for requesting the test is to help the scientist in developing a new diagnostic technique, and the aim is to develop the body of knowledge about the technique or the disease, the request for the test should be regarded as part of the research. For further discussion of this complex area see BMJ 2004;329:624http://bmj.bmjjournals.com/cgi/content/full/329/7466/624.

In international collaborations, other countries requirements for ethical approval for participating clinicians may be different.

Case Studies/ Case Reports

Case reports are usually anonymised and there are rarely ethical issues to be considered as long as consent is obtained. However, some journals may require ethical approval prior to publication.

Data Management and Analysis

Data collected in the course of normal administrative functions of the NHS may be analysed to provide management information to monitor current provision or to plan future developments of the service. Routine data management and analysis is not research. Issues about data protection and confidential information should be handled through normal NHS processes.

Appendix 10. cont.

Service Evaluation

"Evaluation was seen as 'a set of procedures to judge a pilot's merit by providing a systematic assessment of its aims, objectives, activities, outputs, outcomes, and costs'"

J. Newton, J. Graham, K. McLoughlin, A. Moore, D. McTavish, Journal of Management in Medicine 2000; 14:37-47 quoting Evans, D, Steiner, A 1997; NHS Executive, Leeds

Evaluation provides practical information to help decide whether a development or service should be continued or not. Evaluation also involves making judgements about the value of what is being evaluated.

Evaluation:

- May provide cost and/or benefit information on a service
- Uses quantitative and qualitative data to explore activities and issues
- May identify strengths and weaknesses of services
- May include elements of research e.g. collecting additional data or changes to choices of treatment

If a large or complex evaluation study includes a research project (as defined above), the research should be managed within the Research Governance Framework. Where evaluation includes a clinical audit project (as defined above), the audit should be managed through the organisation's clinical audit management systems. In many cases, service evaluation will require collaboration between a number of departments within an organisation. Appropriate management of the evaluation should be agreed across the organisation, and the evaluation should not proceed without permission through the organisation's agreed process.

It can be difficult to distinguish some types of evaluation from research. Although both research and evaluation may involve addressing clearly defined questions with systematic and rigorous methods, research aims to derive generalisable new knowledge. Service evaluation may result in generalisable knowledge but the potential for generalisability is not part of the design of the project. Often a service

evaluation is performed to meet specific local needs. The generalisability of service evaluation may arise through a report or publication where context and methodology are described and readers are able to judge whether the situation is sufficiently representative to their own situation.

Proper governance of research is essential to ensure that the public can have confidence in, and benefit from, quality research in health and social care. Research can involve an element of risk, both in terms of return on investment and sometimes for the safety and well-being of the research participants. Managing innovative work within the NHS requires an assessment of the risks involved and appropriate systems to manage these risks. In assessing the appropriate systems to manage projects which are difficult to categorise, a risk-based approach would include assessment of the risks to others of undertaking the work without appropriate rigour.

Service evaluation which is relevant only to the population or setting upon which it is based would generally be low risk. Evaluation concerned with producing internal recommendations for improvements that are not intended to be generalised beyond the setting in which the evaluation took place should therefore not be managed within the Research Governance Framework, and other appropriate systems should be used. These might include for example authorisation and oversight by a clinical effectiveness manager or a senior person in the department/ unit in which the evaluation is based.

If it is intended that the results of the service evaluation are to be used to influence practices or processes outside the immediate setting and the work was not managed within the Research Governance Framework, there would be a risk of the public being exposed to changes without a sound evidence base. Where it is intended to publish the results of an evaluation in a form that
aims to generalise the results to others situations, the evaluation should therefore be managed within the Research Governance Framework.

Appendix 10. cont.

Ethical review of research

"2.2.1 The dignity, rights, safety and well-being of participants must be the primary consideration in any research study.

2.2.2 The Department of Health requires that all research involving patients, service users, care professionals or volunteers, or their organs, tissue or data, is reviewed independently to ensure it meets ethical standards."

Research Governance Framework for Health and Social Care, Second edition, 2005
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=Wde1Tv

Ethical review by an NHS Research Ethics Committee is required in the circumstances set out below:

"3.1 Ethical advice from the appropriate NHS REC is required for any research proposal involving:

a) Patients and users of the NHS. This includes all potential research participants recruited by virtue of the patient or user's past or present treatment by, or use of, the NHS. It includes NHS patients treated under contracts with private sector institutions.

b) Individuals identified as potential research participants because of their status as relatives of carers of patients and users of the NHS, as defined above

c) Access to data, organs or other bodily material of past or present NHS patients

d) Fetal material and IVF involving NHS patients

e) The recently dead in NHS premises

f) The use of, or potential access to, NHS premises or facilities

g) NHS staff – recruited as research participants by virtue of their professional role"

Governance Arrangements for NHS Research Ethics Committees, July 2001 *http://www.dh.gov.uk/assetRoot/04/05/86/09/04058609.pdf*

In addition, the Medicines for Human Use (Clinical Trials) Regulations 2004 require that all clinical trials of investigational medicinal products falling within the remit of the regulations should receive a favourable opinion from an appropriate ethics committee. (The Medicines for Human Use (Clinical Trials) Regulations 2004 http://www.hmso.gov.uk/si/si2004/20041031.htm)

Research meeting the above criteria requires ethical review by an NHS Research Ethics Committee. However, ethical issues are raised in other forms of innovative work, particularly where direct interaction with patients, service users or carers will take place. Where clinical or university ethics committees are not available this work may be referred to an NHS Research Ethics Committee, who may undertake to review the project. Review of these projects within the NHS Research Ethics Committee system does not mean that the project is required to follow the NHS permission process for research as set out in the Research Governance Framework.

Appendix 11: Literature data extraction

Updated overview of six systematic literature reviews 2001- Dec. 2014 and five exclusions.

[Short-term psychodynamic psychotherapies (STPP); Randomised Controlled Trials (RCTs); Medically Unexplained Symptoms (MUS); Somatoform Disorders (SDs); Effect Size (ES); Standard Mean Differences (SMD); Confidence Interval (CI); Health Care (HC); Primary Care (PC); Secondary Care (SC); Mental Health (MH); Treatment as usual (TAU); Patients (Pts); Cognitive-Behavioural Therapy (CBT); Functional Somatic Symptoms (FSS); Irritable Bowel Syndrome (IBS)]

Review Authors with publication date	**Review title**	**Review purpose**	**Search parameters**	**No. & type of studies reviewed**	**N=**	**Narrative Results**	**Meta-analysis**	**Author recommendations (***JP comments)*
Abbass, Hancock, Henderson & Kisely (2006/2009)	STPP for common mental disorders	To explore the differential effects of STPP for different disorders.	RCTs only in Cochrane, MEDLINE, CINAHL, EMBASE, PsychINFO, DARE & Biological abstracts	23 RCTs	1431 Somatic measures used for 990	8 of the RCTs addressed MUS/ SDs: STPP treatments appear effective for a broad range of common mental disorders; modest to moderate benefit which generally persist in the longer term	-	Economical approach for hard to treat patients. What aspect of the treatments had most bearing on the outcome?

Review Authors with publication date	**Review title**	**Review purpose**	**Search parameters**	**No. & type of studies reviewed**	**N=**	**Narrative Results**	**Meta-analysis**	**Author recommendations (***JP comments)*
Abbass, Kisely & Kroenke (2009)	STPP for Somatic Disorders	To critically review data from RCT & non-RCT designs in order to examine the effectiveness of STPP for patients with somatic symptom disorders	Clinical trial, RCT, Naturalistic Cochrane from 2005, MEDLINE from 1966, PsychINFO from 1967	23 studies 13 RCTs 10 pre-post studies with controls 14 studies meta-analysed	1870 873 535	Medium to large effect on short and medium term results. Shows strong effects in the sub-analyses for emotion-focused STPP models. 91.3% of 21/23 studies reported significant or possible effects on physical symptoms 91.6% of 11/12 studies reported the same for psychological symptoms	0-3/12 outcome (ES= 0.58-0.78) moderate relative to controls. Medium term outcome for SD (SMD -0.87, 95% CI[-1.37 to 0.38], Z=3.45, p<0.001) fixed effect model.	Acute Care (AC) & Primary Care (PC) studies were not reported separately Most treatments reported not manualised Good adherence to STPP found reduced HC costs STPP could be considered before medication or physical procedures

Review Authors with publication date	**Review title**	**Review purpose**	**Search parameters**	**No. & type of studies reviewed**	**N=**	**Narrative Results**	**Meta-analysis**	**Author recommendations (***JP comments)*
Abbass, Kisely, Town, et al. (2014)	STPP for common mental disorders including SDs	Update of 2006 review: To evaluate the efficacy of STPP for adults with common MH disorders against waiting list or TAU controls..	RCTs Cochrane (CCDANCTR) to Feb 2014. Central Medline, Embase, Cinahl, PsycINFO, Dare & Biological abstract to July 2012. Ref lists of papers and contact with large group of STPP researchers to find new studies	33 RCTs 20 studies used for outcome data	2173	Except for somatic measures in the short term, the general, somatic, anxiety and depressive symptoms showed reduction in short and longer term suggesting significantly greater improvement versus control groups Effect sizes increased in long-term follow up but not all statistically significant	No statistical results or meta-analyses given	STPP continues to show promise, with modest to large gains for a variety of people. Variability in treatment delivery and quality may limit the reliability of estimates of effect for STPP Not all studies used manualised treatment models Not all used observer or self-related outcomes Larger studies of higher quality and specific diagnoses are warranted *(How long would it take to cover all permutations of PPS to find the definitive answer of efficacy?)*

Review Authors with publication date	**Review title**	**Review purpose**	**Search parameters**	**No. & type of studies reviewed**	**N=**	**Narrative Results**	**Meta-analysis**	**Author recommendations (***JP comments)*
Leichsenring (2005)	Are psychodynamic & psychoanalytic therapies effective? A review of empirical data	Part 1: To critically review the evidence for psychodynamic therapies in specific psychiatric disorders Part 2: To assess effectiveness naturalistic studies (not accepted by the APA)	RCTs, reviews & meta-analyses MEDLINE from 1966, PsychINFO from 1967, 1960-2004 Naturalistic studies to 2004	22 RCTs 4 studies addressed SDs & FSS	166	STPP feasible & more effective than usual care in 1 study for 2/3ds of the cohort and significantly superior than controls in 3 studies Included effectiveness and quasi-experimental studies which did not systematically over estimate the effects of psychotherapy	Narrative review No statistical or meta-analysis given	'Psychodynamic psychotherapy has shown to be a cost effective treatment' with outcomes stable over 12/12 follow up Not enough demographic info reported, who delivered and in what setting The interpersonal process of application of any therapy protocol should be studied to find what works and how Argue inclusion of effectiveness studies with RCTs for naturalistic outcomes to be included to support reasoned evidence and alternative explanations of efficacy

Review Authors with publication date	**Review title**	**Review purpose**	**Search parameters**	**No. & type of studies reviewed**	**N=**	**Narrative Results**	**Meta-analysis**	**Author recommendations (***JP comments)*
Raine, Haines, Sensky et al. (2002)	Systematic review of mental health interventions for pts with common somatic symptoms: can research evidence from secondary care be extrapolated to primary care?	As title Populations with defined FSS	RCTs, reviews & meta-analyses Cochrane, PsycLIT & EMBASE English lang 1966-Sept 2001	2 meta-analyses, 61 RCTs: 41 in SC 20 in PC *Guthrie study 1991, 1993 using STPP showed at l year follow-up decrease in depression and somatic symptoms. Svendlund STPP study 1983, 1985 showed at 1 year follow up decrease in pain and dysfunction		Too many differences in treatment regimes within PC and SC Lack of demographic & drop-out details. CBT is helpful for chronic back pain and SSRIs benefit pts with IBS. *STPP interventions were included for the review but excluded from meta-analysis Only results from CBT trials were meta-analysed. **In primary care no difference in effectiveness found in reduction of Chronic Fatigue between CBT and counselling.**	No meta-analysis of STPP interventions	Better results in SC. Found lack of studies in PC. Only 8 studies used treatment manuals Identify elements of interventions that can be used in PC Pragmatic studies in PC by Dr, nurse or counsellor on unselected pts., Studies need info on content and quality of intervention Use validated rather than non-validated outcome measures

Review Authors with publication date	**Review title**	**Review purpose**	**Search parameters**	**No. & type of studies reviewed**	**N=**	**Narrative Results**	**Meta-analysis**	**Author recommendations (***JP comments)*
Van Dessel, den Boeft, van der Wouden, et al., (2014)	Non pharmacologic al interventions for SDs and MUS in adults	To assess the effect of all non-pharmacologic al interventions for all forms of PPS against controls (TAU, waiting list, placebo, enhanced care, or other psychological therapy)	Cochrane Library-Embase, Medline & PsycINFO, Register of controlled trials, & cited reference search in Web of Science, grey lit, conf proceedings, internat. Trial registers & relevant systematic reviews to Nov 2013.	21 studies with randomised participants	2658 **1081	14 studies used forms of CBT 7 studies comprised: behavior therapies, 3rd wave CBT, psychodynamic and integrative therapies Mean sessions 1-13 over 1 day to 9 months 2 week to 24 month follow-ups 11 studies (52%) had loss to follow up of more than 20% CBT only studies had similar results: **5 studies showed no clear evidence of difference between enhanced care and CBT.**	Pooled data from studies using SMD, Risk Ratio (RR) & Random Effects Model for primary outcomes severity of somatic symptoms & acceptability of treatment **10 studies showed small to medium effect size in reduction of symptom severity SMD -0.34; 95% CI [-0.53 to -0.16] Effects were durable at 12/12	All therapies were superior to TAU or wait list controls but effect sizes were small Compared with TAU and wait list, CBT reduced somatic symptoms with small effect, but there were substantial differences in outcomes across the studies CBT was not found superior to enhanced care Quality of evidence low to moderate The number of studies of other treatment modalities needs to be increased Interventions may be more effective with milder MUS/PPS or of shorter duration, this needs further testing c/o risk factors in recurrence Yet unclear which intensity effective for which pts. c/o developing pt choice of treatment

Five excluded systematic reviews:

Excluded Reviews	**Review title**	**Review purpose**	**Search parameters**	**No of studies reviewed**	**Results/ Author recommendation**	*Critique by JP with reason for exclusion*
Smits, F., Wittkampf, K. et al. (2008)	Interventions on frequent attenders (FAs) in primary care (PC)	Which interventions are effective in influencing morbidity, quality of life (QoL) & health care utilisation in FAs in PC?	MEDLINE, Embase & PsychINFO	5 RCTs	Results could not be meta-analysed Found no evidence that it is possible to influence HC attendance or improve QoL for FAs in primary care To look at HC use over 2yrs	*The term 'frequent attender' (F.A.) was not well-enough defined and so the question was too broad* *Researchers need to find out what are the characteristics of those who consult frequently* *No mention of patient views* *No mention of MUS/PPS or psychodynamic interventions*
Kroenke, K. 2007	Efficacy of treatment for somatoform disorders (SDs): a review of RCTs	To determine which treatments are efficacious for SDs-what is the strength of evidence for particular treatments? Focus on FSS & symptom specific disorders	Searched in MEDLINE only 1966-2006. Included all therapies but excluded before & after studies	34 RCTs	Most evidence was found for CBT interventions Recommends that other therapy interventions should be studied	*Quote:* 'A variety of other treatments have been evaluated for which the results have been either negative or inconclusive'. *There was no inclusion of STPP studies due to the exclusion criteria*

Excluded Reviews	**Review title**	**Review purpose**	**Search parameters**	**No of studies reviewed**	**Results/ Author recommendation**	*Critique by JP with reason for exclusion*
Sumathipala, A. (2007)	What is the evidence for the efficacy of treatments for somatoform disorders? A critical review of previous intervention studies.	To review published literature for highest levels of evidence on the efficacy of treatment for patients with MUS.	Medline and Embase to 2007, PsycINFO to 2006, ref lists from primary studies. RCTs featuring Functional Somatic Syndromes (FSS), were excluded but included if inclusive with other PPS. (Creed 2003 excluded)	6 systematic reviews up to 2000 14 RCTs since 2000 Only 2 CBT trials in primary care [Speckens, 1995; Van Dulmen, 1997]. No meta analysis of 14 RCTs since 2001.	Limited evidence for dynamic psychotherapies for MUS; reporting, 'have not shown convincingly better results than placebo or TAU but harm may also occur from dynamic intervention' refers to (Andrews, 1991 Psychotherapy: From Freud to cognitive science. Med J Aust. 16, pp. 845-8.) ^ No systematic reviews were found for STPP as FSS excluded Examined level II evidence Individual RCTs were found heterogenous Variants on CBT not made clear Level II evidence only	1 CBT study (Smith et al. 2006) from 2001-2006 STPP studies are mentioned only related to publications 1983-1996 *STPP studies excluded from results* ^*JP: Very negative approach to STPP but author suggests* qualitative studies to identify strategic components embedded within RCTs Even if efficacy found, more pragmatic controlled trials are recommended to transfer to realities of practice settings Acknowledges that Evidence-Based Medicine (EBM) is only useful if subjective elements of patients views and values are acknowledged

Excluded Reviews	Review title	Review purpose	Search parameters	No of studies reviewed	Results/ Author recommendation	*Critique by JP with reason for exclusion*
Allen, L.A., Escobar, J.I., Gara, M.A., & Woolfolk, R.L. (2002)	Psychosocial treatments for multiple unexplained physical symptoms: a review of the literature.	To review the evidence of efficacy of psychosocial interventions for MUPS	1966-2001	34 RCTs with comparison groups.	25% of studies showed long term benefits. As a summary, psychosocial interventions did not show lasting benefit for polysymptomatic somatisers	*Review not used as no primary studies included in dates 2001-2014* *JP: too wide a definition of treatment to be meaningful for any psychotherapy intervention.*
Sollner & Schussler (2001)	Psychodynamic therapy in chronic pain patients	To evaluate the evidence on the indication and modification of psychodynamic therapy procedures & their effectiveness in the treatment of pts with chronic pain	Studies with comparison groups in MEDLINE 1984-2000, Psyndex 1997-2000, EBM 1996-2000 in English & German	6 studies with comparison groups N=450	Psychodynamic (PD) therapy is indicated in pts with psychiatric co-morbidity and for somatoform pain disorder. Modifications were: more structure, more overt support particularly initially More controlled multi-center studies to evaluate the effectiveness of PD approaches in different pain disorders, plus investigate different settings & modifications of PD therapy. Greater importance must be given to the physical level & to the 'holding function' of the therapist.	*Not included as no primary studies included in dates 2001-2014*

Comments on excluded reviews

Although the titles of these four reviews initially might have indicated the possibility of relevance to the research question posed, brief or Short-term Psychodynamic Therapies (STPP) were given little attention by the authors. Smits, et al., 2008, proved to have a poor research question and Kroenke, a well-published researcher on the topic, searched only in MEDLINE, Kroenke's exclusions meant that the few experimental STPP studies that had been undertaken over the search years were not included. Kroenke's and Smits' reviews made some attempt to locate articles in the bibliographies of the selected research papers and Kroenke, from reviews of selected treatments, but this was the extent of evidence. ^Sumathipala's summary statement regarding dynamic therapies could be interpreted as misleading to the non-researcher reader.

Appendix 12: 12 primary studies data extraction

Summarised breakdown of content of the 12 primary research studies Tables A-D:

Table A: Study setting, intervention, frequency and delivery

[[1]Presenting troublesome physical symptom with no known organic cause found (PPS); [2]General Medical Practitioner (GP); [3]British Association for Counselling & Psychotherapy (BACP); +usual therapy session time is 50-60 minutes per session; Mental Health (MH)]

Table A Primary research study	Healthcare setting	Presenting PPS[1]	Referral pathway	Type of STPP intervention	No. and frequency of sessions (length of session if exceptional)+	Intervention by
Abbass, Campbell, Magee & Tarzwell (2009) Intensive short-term dynamic psychotherapy (ISTDP) to reduce rates of emergency department return visits for patients with MUS. http://www.istdp.ca/docs/CJEM_2009.pdf.	Out-patient PPS	Any form of PPS	Following visit to A&E with PPS	Intensive Short-Term Dynamic Psychotherapy (ISTDP) (Davanloo, 2005; Abbass, 2005)	1 to 20+ weekly sessions	Psychologist Senior psychiatry residents Psychiatrist Family physician with 2yrs experience of the model
Carrington, Rock & Stern (2012). Psychoanalytic thinking in primary care: The Tavistock Psychotherapy Consultation Model. *Psychoanalytic Psychotherapy*, 26(2), pp.102-120.	Primary/ Community Care	Chronic PPS	GPs to a MUPS/PPS service	Dynamic Interpersonal Therapy (DIT) (Lemma, Target, Fonagy 2011), Mentalisation-Based Therapy (Bateman, Fonagy, 2004) and psychodynamic principles to support GP case-work	31% seen weekly 40% seen fortnightly 15% monthly 14% other frequency Flexible over 12 months	Clinical psychologists Nurses Social workers Psychiatrists Psychotherapists in partnership with GPs

Table A Primary research study	Healthcare setting	Presenting PPS[1]	Referral pathway	Type of STPP intervention	No. and frequency of sessions (length of session if exceptional)+	Intervention by
Creed, Tomenson, Guthrie, Ratcliffe, et al. (2008) The relationship between somatization and outcome in patients with severe IBS *Journal of Psychosomatic Research*, 64, pp.613-620	Out-patient Gastro-enterology	Intractable Irritable Bowel Syndrome (IBS)	Specialist Hospital Consultant (SHC)	Psychodynamic Interpersonal Therapy (PIT) (Guthrie, 1991) based on Hobson (1985)	Up to 8 sessions over 3 months 2-hour assessment 45 minute follow ups	Therapists trained in PIT
Guthrie, Margison, Mackay et al. (2004) Effectiveness of PIT training for Primary Care Counsellors. *Psychotherapy Res.*, 14(2); pp.161-175	Primary Care	Depression, somatization or suicidal ideation	GP	Psychodynamic Interpersonal Therapy (PIT) (Shapiro & Firth, 1987)	8 weekly sessions	BACP Accredited primary care counsellors Trained over 12 weeks in PIT techniques: 1 intensive week plus 3 months of weekly supervision in small groups of 3-5
Hinson, Weinstein, Bernard, Leurgans & Goetz, (2006) Single-blind clinical trial of psychotherapy for treatment of psychogenic movement disorders. *Parkinsonism and Related Disorders,* 12, pp.177-180.	Out-patient Neurology	Psychogenic Movement Disorders	SHC	Brief Psychodynamic Psychotherapy (Davanloo, 1980). Also prescribed anti-depressants or anxiolitics to treat co-existing anxiety or depression	12 sessions weekly	Psychiatrist

Table A Primary research study	Healthcare setting	Presenting PPS[1]	Referral pathway	Type of STPP intervention	No. and frequency of sessions (length of session if exceptional)+	Intervention by
Junkert-Tress, Schnierder, Hartkamp et al. (2001) Effects of short-term dynamic psychotherapy for neurotic, somatoform, and personality disorders. *Psychotherapy Res* 11(2) 187-200.	Out-patient PPS	Any form of PPS	SHC	Short-term Dynamic Psychotherapy Therapy (STDP) (Strupp & Binder, 1984)	Up to 25 weekly sessions	Psychotherapists with psychodynamic therapy experience for >2 years
Mayor, Howlett, Grunwald & Reuber (2010) Long-term outcome of brief augmented PIT for psychogenic non-epileptic seizures. *Epilepsia , 51(7)*, pp. 1169-1176.	Out-patient Neurology	Non-Epileptic Seizure (NES)	SHC	Brief Augmented Psychodynamic Interpersonal Therapy (PIT), adapted (Hobson, 1985)	Weekly or fortnightly up to 19 sessions 2 hour assessment	Psychotherapist Experienced in neurology psychotherapy service
Payne & Stott (2010) Change in the moving BodyMind approach: Quantitative results from a pilot study on the use of the BMA to psychotherapeutic group work with patients with MUS. *Counselling &Psychotherapy Research*, 10(4), pp. 295-306.	Community Care	Any form of PPS	Self or GP	Adapted Dance Movement Therapy (DMT) to Dance Movement Psychotherapy (DMP) With Bodywork (Adler, 2002, Pallero, 2006)	12 weekly 2-hour group sessions	Experienced DMP Therapist

Table A Primary research study	Healthcare setting	Presenting PPS[1]	Referral pathway	Type of STPP intervention	No. and frequency of sessions (length of session if exceptional)+	Intervention by
Rohricht & Elanjithara, (2013) Management of Medically Unexplained Symptoms: outcomes of a specialist liaison clinic. *Psychiatric Bulletin*, 38, pp. 102-107.	Community Mental Health (MH) PMUS	Any form of PPS	GPs, SHC & MH patients unable to find treatment elsewhere	Body-orientated psychological (BOPT) group therapy (Rohricht & Elanjithara, 2013)	Over 24 months group intervention: up to 15 sessions	Psychiatrists Trained in BOPT
Sattel, Lahmann, Gundel, Guthrie et al (2012). Brief psychodynamic interpersonal psychotherapy for patients with multisomatoform disorder. *BJ Psychiatry*, 100, pp. 60-67.	Out-patient	PPS found within the referring clinics	SHC: Neurology, Internal Medicine, Pain clinics, Orthopaedics and private practice.	Psychodynamic Interpersonal Therapy (PIT) (Guthrie, in Hardy, Barkham, Shapiro et al., 2011).	12 weekly sessions 1st session 90 mins, follow-up sessions 45 mins	Psychologists Physicians Minimum of 3 years training in psychotherapy and also trained in use of therapy manual.
Tschuschke, Weber, Horn, Kiencke, Tress (2007). Ambulante Psychodynamische Kruzgruppenpsychotherpie bie Patienten mit somatoformen Storungen. *Zeitschrift fur Psychiatire, Psychologie und Psychotherapie,* 55(2), pp. 87-95.	Out-patient	Any form of PPS	GP & SHC	Intra-psychic dynamic group therapy (Tschuschke, Horn, Ott & Tress 1998)	20 weekly x 90 minute group sessions.	Psychoanalytic psychotherapists

Table A Primary research study	Healthcare setting	Presenting PPS[1]	Referral pathway	Type of STPP intervention	No. and frequency of sessions (length of session if exceptional)+	Intervention by
Ventegodt, Thegler et al. (2007) Clinical holistic medicine (Mindful, short-term psychodynamic psychotherapy complemented with body-work) in the treatment of experienced physical illness and chronic pain. *The Scientific World Journal,*7,pp.310-316.	Private health clinic	PPS with self-rating of 'seriously ill'	Self-referrals	Mindfulness Short-term Psychodynamic Psychotherapy (STPP) with undefined 'Bodywork' (Ventegodt, Anderson, Merrick, 2003)	20 sessions over 14 months	Masters students of The Nordic School of Holistic Medicine

Table B: Number of participants in each study and drop outs

Primary research study	Number of participants	Number in control group	Drop outs
Abbass, Campbell, et al, 2009	N=50 n=26 had 2 or more therapy sessions	No control group	40%
Carrington, Rock & Stern, 2012	N=44	No control group	16% Did Not Attend (DNA) assessment 8% DNA through therapy
Creed, Tomenson, et al., 2008	N=257	Random allocation in groups of 12	31% of the STPP group 50% of the SSRI group
Guthrie, Margison, et al., 2004	N=34	No control group	0 drop out
Hinson, Weinsein, et al., 2006	N=10	No control group	10%
Junkert-Tress, Schnierder, et al., 2001	N=87 at outset (n=24 with Somatoform Disorders)	No control group	13.7% terminated treatment early 14% of the remainder
Mayor, Howlett, et al., 2010	N=66 pro & retrospective cases	No control group	29% did not return their follow-up questionnaires-demographics no different from those who did
Payne & Stott, 2010	N=18	No control group	25% (not included in the N=18)
Rohricht, & Elanjithara. 2013	N=106 n=41 engaged more than once	No control group	23% on or prior to assessment
Sattel, Lahman, et al., 2012	N=107	N=104 Enhanced Medical Care EMC	19% for PIT; 27% for EMC
Tschuschke, Weber, et al., 2007	N=50	No control group	Unclear
Ventegodt, Thegler et al., 2007	N=31	No control group	42%

Table C: Pre, end-therapy and longer term measured outcomes (see Explanatory Notes below)

Study	Measures	Baseline				End of Therapy						3/12						6/12 longer outcomes{>6/12}			
		Mean & [SE] as given	*SD*	*N*	*ES*	*Mean*	*SD*	*N*	*t*	*Sig p =*	*ES*	*Mean*	*SD*	*n*	*t*	*Sig p =*	*ES*	*Mean [SE]*	*SD*	*n*	*ES*
Abbass, et al., 2009[1]	BSI global	1.21	0.58	26		.86	.63	26	** 2.84,<.01			-					-	-			
	BSI somat	1.61	1.1	26		1.04	1.0	26	** 2.45, .02			-					-	-			
	Likert 1-10 on service satisfy.	-				7.4	2.1	26				-					-	-			
Carrington, et al., 2012	PHQ-9	-		44	[2]0.2	-			-		[3]0.7	-					-	-			
	GAD-7	-			0.1	-			-		0.9	-					-	-			
	Schwarz	-			0.0	-			-		0.5	-					-	-			
	WSAS	-			0.1	-			-		0.6	-					-	-			
Creed, Tomenson et al. 2008	SCL-90 somat	1.12	0.76	251		-			-		-	-					-	-			[4]0.61
	SF-36 phys Highest somat score groups	31.1 [1.1]		65		-					-	-					-	{12/12} 38.1*** [1.3]		[5]49	
	HRSD	15.1 [0.8]																{12/12} 11.9*** [0.8]			

Study	Measures	Baseline				End of Therapy						3/12						6/12 longer outcomes{>6/12}			
		Mean & [SE] as given	*SD*	*N*	*ES*	*Mean*	*SD*	*N*	*t*	*Sig p =*	*ES*	*Mean*	*SD*	*n*	*t*	*Sig p =*	*ES*	*Mean [SE]*	*SD*	*n*	*ES*
Guthrie, et al., 2004	CORE-OM	1.98	0.63	34		1.15	0.70		[6] *** (40) 7.12, .001			-					-	-			
Hinson, [7] et al., 2006	PMDRS	71.2	42.5	9	-	[7]29.0	20.6		* - .019		-	-					-	-			-
	HRSD	14.8	7.1		-	3.9	2.1		** .009		-	-					-	-			-
	Beck Anxiety	19.7	10.2		-	4.0	2.4		** .002		-	-					-	-			-
	GAF	62.3	6.1		-	69.4	9.2		** .008		-	-					-	-			-
Junkert-Tress, et al., 2001	SCL-90-R	0.82	0.45	24	-	0.49	0.32	22	-		0.69	-						0.53 {12/12} {0.58}	0.40 0.50	21 18	0.60
Mayor, et al., 2010	SF-36 Physical	[8]34.55	-	47	-	[8]-			-		-	[9]-					-	[8]- [9]			
	SF-36 Mental	35.1	-		-						-						-	{12-61}		47	
	CORE-OM	51	-		-						-						-				

Study	Measures	Baseline				End of Therapy						3/12						6/12 longer outcomes{>6/12}			
		Mean & [SE] as given	*SD*	*N*	*ES*	*Mean*	*SD*	*N*	*t*	*Sig p =*	*ES*	*Mean*	*SD*	*n*	*t*	*Sig p =*	*ES*	*Mean [SE]*	*SD*	*n*	*ES*
	PHQ-15	15	-		-						-						-				
Payne & Stott,[10] 2010	CORE-OM Wellbeing Problems Function Risk	-	-	17	-	-					-	 -0.76 -0.70 -0.54 -0.15	 0.75 0.84 0.77 0.46	 17 prs	 - ,.001 - ,.004 - ,.011 -,.204	 0.72 0.65 0.58 0.31	-				-
Rohricht, & Elanjithara,[11] 2013	HRSD	18.4	8.4	106	-	-					-	[11]18.2	7.9	12	0.93, **n.s.**	-	-				-
	PHQ-15	17.6	6.7		-	-					-	15.1	4.9		-2.2, .05	-					
Sattel, et al.[12] 2012	PHQ-15	15.2	5.2	107	-	13.8	5.3	95			-	-				-		[12]{9/12} {12.7}	5.8	96	-
	SF-36 phys	29.0	6.4			[13]31.3	8.1											[13]{34.3}	9.3		
	PHQ-9	12.9	5.7			10.3	6.0											-			
	WI-7	3.9	2.1			3.5	2.3											-			

Study	Measures	Baseline				End of Therapy						3/12						6/12 longer outcomes{>6/12}			
		Mean & [SE] as given	*SD*	*N*	*ES*	*Mean*	*SD*	*N*	*t*	*Sig p =*	*ES*	*Mean*	*SD*	*n*	*t*	*Sig p =*	*ES*	*Mean [SE]*	*SD*	*n*	*ES*
Tschuschke, et al.,[14] 2007	SCL-90	0.93	0.44	49	-	0.71	0.44	50	-, ***	.001	.48	-						0.65 {12/12} {0.56}	0.45 0.41	45 35	.61 .76
	GAF	58.84	8.97	49	-	69.18	10.0	50	-, ***	.001	1.16							69.83 {73.24}	10.79 11.79	45 35	1.24 1.36
Ventegodt, et al., 2007	QoL-5 Phys Mental QoL1	[15]4.000 3.500 3.916		12 12		[16] 2.666 2.250 2.500		18 1	9.4, *** 4.1, ** 4.9, ***	.000 .002 .000		-						-			

p values p<.05*, p<.01 **, p<.001***

Specialist terms: Somatoform Disorders (SDs); Standard Deviation (*SD*); Psychodynamic Psychotherapy (PP); Enhanced Medical Care (EMC); Effect size (*ES*); Mean (*M*); Standard Deviation (*SD*); Standard Error of Mean (*SEM*). See explanatory notes below. Measure ratings (see indication of high/low ratings PTO)

Table C Explanatory notes

[1] Those referred but not seen were found with a 42% raised increased or 1.9 (SD 7.9) to 6.5 (12.9) visits to A&E/ED per year, revisit rates for the treated group Mean 3.2(69%) ED visits (6.4) 95%CI [1.3-5.0], $p< .001$; the pre/post BSI Global ($p< 0.01$), BSI Somat ($p< 0.02$); the post *t* means were near to pathological cut-off scores of 0.82-0.93 respectively (Derogatis, 1993), (Abbass, et al., 2009)

[2] ES small (0.2 or less) after assessment only, [3] comparison to IAPT for anxiety and depression in their first year of operating was medium (ES= 0.7), 47%-82% improvement for those who entered therapy, secondary analysis for PPS and non-PPS outcomes similar for anxiety and depression No longer term measures (Carrington, et al., 2012)

[4] Overall ES 0.61 for psychotherapy, n= 22, 0.67 for SSRI medication, n=11 for TAU *p* value for comparison between treatment groups *p*= .009; [5]Mean change in most severe scoring PPS group using SF-36 phys. after 15/12 for PIT intervention, n=22, score mean 36.6 (2.2) and for Paroxetine intervention, n=11, 35.5(1.9) and TAU group 26.4 (2.7) (adjusted *p*= .014) (Creed, et al., 2008)

[6] Clinical and non-clinical variables analysis post therapy reported as 50% (n=17) clinically significant and reliable change with the PIT intervention. Non-clinical score previously found as 0.76(0.59) (Guthrie, et al., 2004)

[7] Mean improvement 75%, range 52-100% (Hinson, et al., 2006);[8]Median values given, no correlations found between baseline variables and change in seizure frequency therefore follow-up scores at end of therapy not reported, [9] a further 40.4% had reduction in seizures >50% and health care utilization reduced from baseline to follow-up *p*<.039 (Mayor, et al., 2010)

[10] With the exception of 'risk' the effect sizes were reported 'all greater than the excepted benchmark of 0.5 for large effects', CORE-OM on wellbeing change: Baseline to follow-up at 3/12 No. of pairs=17, (*M*=-0.76, 95% CI [-1.15, -0.38] (SD=0.75), *p*<.001, ES= 0.72, Paired t tests reported as highly significant (Payne, et al.,2010)

[11] Non-significant for depression scores, for PHQ-15 (95% CI [0.005 to 3.6] *t*=-2.2, *p*<.05), 'significant improvement' (Rohricht, et al., 2013);

[12] At 9/12 Group mean difference for PHQ-15 'significant improvement' (M -1.12, 95%CI [-2.65 to 0.31], *p*=.01), [13] SF-36 Small to medium ('moderate') between group effect size *d*=0.42, 95%CI[0.15 to 0.69], *p*=.001, consistent with reported treatment effects of CBT for bodily distress (Sattel, et al., 2012)

[14] SCL GSI and GAF reached high significance *p*= .001 for post, 6/12 and 12/12 follow-up score changes (Tschuschke et al., 2007)

[15] At baseline 31 rated themselves physically ill as 'Bad' or 'Very bad' using Likert scale 1-5, [16] At end of therapy 12/31 (38.71%) self assessed physically well and of responders (58% *n*=18 questionnaire return) remained feeling physically ill 6/31(19.35%). There were 13 non-responders/drop-outs. Of all 31 cases (taking drop-outs and non-responders as negative *n*=13), 33.3% reported fully cured as 'good' or 'very good', 66.7% improving (ie felt neither bad nor good). Those reporting physically well post-therapy n=12, (38.78%, 95%CI, [22-58%], *p*= .05) (Ventegodt, et a., 2007)

Measures showing higher score as poor:

Beck Anxiety

Brief Symptom Inventory (BSI)

(CORE-OM) (34 item measure)

Generalised Anxiety Disorder (GAD-7) (IAPT overall effect size in their first year was 0.7)

Hamilton Rating Scale for Depression (HRSD) score of 20 or above indicates severity

Patient Health Questionnaire-9 for depression (PHQ-9) (IAPT overall effect size in their first year was 0.7)

PHQ-15 for somatic symptoms, (0-30) above 10 is severe

Psychogenic Movement Disorder Rating Scale (PMDRS) measurers the physical phenomena and function

Quality of Life (QOL5) & QOL1

Symptom Checklist -90-Revised (SCL-90-R)

Global Severity Index (GSI) for Somatoform Disorders

Whitely Index: Health Anxiety (WI-7)

Work & Social Adjustment Scale (WSAS) higher score is poor

Visual Analogue Scale (VAS) for pain

Measures showing higher score as improved:

Global Assessment of Functioning (GAF)

Schwarz Outcome Scale

Short-Form Health Survey (SF36), (36 item physical and mental)

Table D: Therapy model, how was it experienced, active ingredients explored?

Primary research study	Specific therapy outlined	Data collection method for how it was experienced and how the active ingredients were explored
Abbass, et al., 2009	Intensive Short-Term Dynamic Psychotherapy (ISTDP) with reference to Davanloo (1990) and Abbass 'Emotion-focused Interviewing' (2005) • evaluation interview • focus on life situations where there was a strong emotional activation • working together to examine the physical affects of the emotional activation • examine unconscious anxiety affecting smooth or striated muscle, motor tone or cognitive perceptual functioning • techniques to build anxiety tolerance	Use of patient satisfaction survey over a one month period Likert 1-10 n=13; overall satisfaction rated at 7.4 out of 10 (satisfied to very satisfied) What components were helpful? Results: • gaining insight into the physical effects of emotions • an expressed benefit from the process no further detail given
Carrington, et al., 2012	DIT (Lemma, Target, Fonagy 2011) Mentalisation based therapy, (Bateman, Fonagy, 2004)	No qualitative data included in the report. Active ingredients not systematically explored.
Creed, et al., 2008	Psychodynamic Interpersonal Therapy (PIT) Encouraged to discuss emotional symptoms in depth, emotional factors explored, links between emotional factors and PPS identified	No qualitative data included in the report. Active ingredients not systematically explored.
Guthrie, et al., 2004	Follows Shapiro & Firth (1987) Exploratory Therapy Manual, Sheffield Psychotherapy Project: shown effective for somatization in secondary care (SC) (Guthrie, Creed, Dawson, & Tomenson, 1991). Counselling and PIT share humansistic background & exploration of interpersonal relationships	No qualitative data included in the report. Active ingredients not systematically explored.

Primary research study	Specific therapy outlined	Data collection method for how it was experienced and how the active ingredients were explored
Hinson, et al., 2006	STPP with reference to Davanloo (1980) • focus on early life experiences, parenting dynamics, personality traits • links between the above and and current emotions and behaviours prescribed anxiolytics or anti-depressants to treat co-existing anxiety and/or depression	No qualitative data included in the report. Active ingredients not systematically explored. Author suggests study of the specificity of the therapeutic intervention
Junkert-Tress, et al., 2001	Follows Strupp and Binder's(1984) Time Limited Dynamic Psychotherapy and use of Model of Cyclic Maladaptive Pattern (CMP) Emphasis on analysis of transference in the therapist-patient relationship and the patients key conflictual relationships	No qualitative data included in the report. Active ingredients not systematically explored.
Mayor, et al., 2010	Brief augmented psychodynamic interpersonal therapy (PIT) adapted from Hobson (1985) (Howlett et al., shown effective for somatization in secondary care (SC) (Guthrie, Creed, Dawson, & Tomenson, 1991). Counselling and PIT share humansistic background & exploration of interpersonal relationships (Howlett, 2007) • Identifying and changing unhelpful patterns in interpersonal relations • effective processing of emotions, current and painful past memories • techniques of controlling autonomic arousal • track somatic symptoms and linking with emotional triggers • process traumatic memories without retraumatising the patient • symptom/emotion diary • symptom control through breathing exercise, sensory focusing, EFT, relaxation, EMDR; goal setting, anxiety self-management, enlisting family support but encouraging self-care • Noting pre-disposing, precipitating and perpetuating factors (PPP)	No qualitative data included in the report. Active ingredients not systematically explored.

Primary research study	Specific therapy outlined	Data collection method for how it was experienced and how the active ingredients were explored
Payne & Stott 2010 (refer to qualitative results in Payne 2009)	Dance Movement Psychotherapy (DMT) or Dance Movement Therapy//Psychotherapy (DMT//P) uses • natural gestural/postural body language combined with words • emphasis on connectivity between physicality, feelings, thoughts, beliefs, symbolic non-verbal, verbal & imaginative aspects of psychotherapeutic process (Berrol 92) • .elicits subjective views of their symptoms, expectations of and then experience of the therapy	Themes extracted from semi-structured interviews reported in Payne, (2009) of patient and therapist perceptions: 1. More agreements than differences 2. Main themes congruent • time and space to become aware of triggers • links to feelings & circumstances • how to avoid triggers • new strategies • the role of the facilitator • developing awareness of meaning
Rohricht & Elanjithara 2013	Body-Oriented Psychological Therapy (BOPT) group: • combining verbal & non-verbal strategies • focus on emotional processing, expressiveness, movement behaviour & body/self perception • subtle integration of somatic & psychological aspects working with and through bodily symptoms • bioenergetics exercises Psychological processes were not directly addressed	No evidence of exploration of active components or how therapy was experienced in the report.

Primary research study	Specific therapy outlined	Data collection method for how it was experienced and how the active ingredients were explored
Sattel, et al., 2012	Psychodynamic Interpersonal Therapy (PIT) is similar to mentalisation –based therapy: Guthrie, Adaptation of PI model, in Hardy, Barkham, Shapiro et al., (2011) Psychodynamic Interpersonal Therapy). • assumes developmentally based dysregulation of bodily self-experience and relationships rather than unconscious conflicts are the primary basis of the symptoms • links symptoms to emotional states • Includes bodily relaxation therapy & education re MUS in a non-catastrophising manner • associations are established with PPS and earlier relationships that have created 'dysfunctional patterns'	No qualitative data included in the report. Active ingredients not systematically explored.
Tschuschke, Weber, Horn, Kiencke, Tress, 2007	Psychodynamic short-term out-patient group therapy (Tschuschke, Horn, Ott & Tress, 1998) • using psychodynamic and interpersonal features to focus on the physical symptom • prior attendance for 2, 1:1 personal sessions before the group therapy	No qualitative data included in the report. Active ingredients not systematically explored.
Ventegodt, Thegler et al. 2007	Mindful, Short-Term Psychodynamic Psychotherapy complemented with body work (STPP) Described as a fast and efficient holistic tool for the generic therapist for • physical, mental, existential, and sexual problems Body work neither described nor reported here	No systematic reporting on how the therapy was experienced, but the comment-'during the most intensive phase of the therapy, many pts felt 'very bad' for a few days but none of the pts experienced severe or lasting side-effects.'

Appendix 13: RAMESES standards

RAMESES Realist Synthesis publication guidelines (Wong et. al., 2013)

List of items to be included when reporting a realist synthesis
TITLE
1
ABSTRACT
2
INTRODUCTION
3 Rationale for review 4 Objectives and focus of review
METHODS
5 Changes in the review process
6 Rationale for using realist synthesis 7 Scoping the literature 8 Searching processes
9 Selection and appraisal of documents
10 Data extraction 11 Analysis and synthesis processes
RESULTS
12 Document flow diagram
13 Document characteristics 14 Main findings
DISCUSSION
15 Summary of findings
16 Strengths, limitations and future research directions
17 Comparison with existing literature 18 Conclusion and recommendations 19 Funding.

In the title, identify the document as a realist synthesis or review
and 23) in the PRIMSA statement have no equivalent in the RAMESES publication standards for realist reviews.
The order in which items are reported may vary. Realist syntheses are not 'linear' reviews. Some of the processes that are listed may legitimately take place in parallel or have to be revisited at a later date as a review progresses. As a general rule, if a recommended item is excluded from the write-up of a realist synthesis, a justification should be provided.
The RAMESES publication standards for realist syntheses
Item 1: Title
In the title, identify the document as a realist synthesis or review.
While acknowledging publication requirements and house style, abstracts should ideally contain brief details of: the study's background, review question or objectives; search strategy; methods of selection, appraisal, analysis and synthesis of sources; main results; and implications for practice.
Explain why the review is needed and what it is likely to contribute to existing understanding of the topic area.
State the objective(s) of the review and/or the review question(s). Define and provide a rationale for the focus of the review.
Any changes made to the review process that was initially planned should be briefly described and justified.
Explain why realist synthesis was considered the most appropriate method to use. Describe and justify the initial process of exploratory scoping of the literature.
Appendix 13 cont. RAMESES Realist Synthesis publication guidelines (Wong et al. 2013)

While considering specific requirements of the journal or other publication outlet, state and provide a rationale for how the iterative searching was done. Provide details on all the sources accessed for information in the review. Where searching in electronic databases has taken place, the details should include, for example, name of database, search terms, dates of coverage and date last searched. If individuals familiar with the relevant literature and/or topic area were contacted, indicate how they were identified and selected.

Explain how judgements were made about including and excluding data from documents, and justify these.

Describe and explain which data or information were extracted from the included documents and justify this selection.

Describe the analysis and synthesis processes in detail. This section should include information on the constructs analyzed and describe the analytic process.

Provide details on the number of documents assessed for eligibility and included in the review with reasons for exclusion at each stage as well as an indication of their source of origin (for example, from searching databases, reference lists and so on). You may consider using the example templates (which are likely to need modification to suit the data) that are provided.

Provide information on the characteristics of the documents included in the review. Present the key findings with a specific focus on theory building and testing.

Summarize the main findings, taking into account the review's objective(s), research question(s), focus and intended audience(s).

Discuss both the strengths of the review and its limitations. These should include (but need not be restricted to) (a) consideration of all the steps in the review process and (b) comment on the overall strength of evidence supporting the explanatory insights which emerged. The limitations identified may point to areas where further work is needed.

Where applicable, compare and contrast the review's findings with the existing literature (for example, other reviews) on the same topic.

List the main implications of the findings and place these in the context of other relevant literature. If appropriate, offer recommendations for policy and practice.

Provide details of funding source (if any) for the review, the role played by the funder (if any) and any conflicts of interests of the reviewers

Appendix 14: Personal goal attainment

Personal Goal Attainment of the four participants over time

Likert scale 1-7 where 1=no change, 7=completely achieved: participants TG, SQ, BX, TN

Participant Scores on Likert scale	**Work on comms**	**Work on self**	**Regain desire**	**Develop sexual confidence**	**Improve sexual function**	**Greater sexual satisfaction**
TG Goal 1 Time 1 (T1)		2				
T2		4				
T3		6				
Goal 2-T1		2				
T2		5				
T3		6				
Goal 3-T1		2				
T2		4				
T3		5				
Goal 4-T1						1
T2						1
T3						2

Participant Scores on Likert scale	**Work on comms**	**Work on self**	**Regain desire**	**Develop sexual confidence**	**Improve sexual function**	**Greater sexual satisfaction**
SQ Goal 1- T1					1	
T2					5	
T3					5	
Goal 2- T1				1		
T2				1		
T3				6		
Goal 3- T1						1
T2						3
T3 SQ cont.						6
BX Goal 1-T1	3					
T2	4					
T3	5					
Goal 2-T1			1			
T2			3			
T3			5			
Goal 3 T1				1		
T2				4		

Participant Scores on Likert scale	**Work on comms**	**Work on self**	**Regain desire**	**Develop sexual confidence**	**Improve sexual function**	**Greater sexual satisfaction**
T3				5		
Goal 4 T1					1	
T2					3	
T3					4	
TN Goal 1-T1	2					
T2	3					
T3	4					
Goal 2-T1					3	
T2					4	
T3					5	
Goal 3-T1					3	
T2					4	
T3					6	
Goal 4-T1						4
T2						5
T3						6

Appendix 15: Themes

Theme 1: Therapeutic Alliance: sub-themes: distilled content

Themes, sub-themes & content	Exploring in safety	Giving personal value	Encouraging	Non-judgemental talking through
1. Therapeutic Alliance: Generating hope	TG(1)Ref 9 Th: what matters right now, is building trust between us so that we can give it a go.	SQ(3)Ref 2 Th: so really we need to do something that is right for you P: Yeah	TG(2)Ref 4 Th: but you allowed yourself to follow through that flickering decision to come back. Pt: I made the decision because I really do need help.	TG(4)Ref 4 Pt: I feel a little bit sort of like relieved that I've said things, and even thought they've been horrible things but that it's been okay to say them
Giving & getting information	Timing & spacing of appointments	Getting brief medical & social history	Use of emotion	Making links between life events and the body
	TN(2)Ref 5 Th: Okay, yes, and the spaces between the appointments is that tolerable to you? Pt: Yes	SQ(1)Ref 2 Th: So the purpose of our work here, we take full consideration of physical issues and underlying always keep that in mind. SQ(1)Ref 3 Th: looking at the whole person and their environment and what's been happening too. So often it's the combination of those things.	TG(1)Ref 6 Th: a lot of our work is and done through emotion, that's where we find what's really going on for people TG(1) Th: It's not just changing your thinking-it's appreciating everything you feel.	SQ(1)Ref 8 Th:...the knock on effect of life events. If we don't talk it through or talk it out, often it goes into the body in some way. Pt: Right Th: And comes out as some sort of physical symptoms, as far as I understand it Pt: Okay Th: And sometimes that can be a sexual symptom

Invitation to expand on story	Encouragement to tell their story	Following through session by session	Exploring goals	Exploring future hopes
TN(2)Ref 1 - Th: I thought what we could do today is just to ask you first, what is uppermost in your mind today in terms of wanting to talk about anything particular in reference to last time, not? Pt: Okay, most in my mind at the moment is actually, there are two things	TG(1)Ref 3 Th: Now if we were to do some work on this, we could do some interesting exploration on maybe…	BX(2)Ref 2 Th: So would it be helpful just for us to go back to those two experiences? Pt: Absolutely, yes	SQ(1)Ref 4 Th: So I won't know at the outset what's relevant until we have a look around and see where there's something we can work on that would help to get you to where you want to be	BX(5)Ref 2 Th: it will be a point in time we can met just gather up what your experiences have been Pt: Yea Th: And look ahead to see what you need next. Pt: Yea
Joint enterprise	Co-equals	Checking if OK to continue	Checking back	Offering control over ending
Theme 1 cont.	BX(1)Ref 6 Th: So it's a sort of creative enterprise between us	TN(1)Ref 2 Th: So if you were to do some work carrying on from today because we have made a start today. Firstly would you feel comfortable doing that?	TN(6)Ref 3 Th: …what has that been like, talking stuff through? Has it been useful, not useful – what influence has it had do you think over getting back on track?	BX(7)Ref 2 Th: So what do you feel would be best for you, at this stage? Pt: I would like to come back and see and talk to you in the future.

Theme 2: Exploring the nature of PPS and initial goals for therapy: distilled content (over five following pages)

2. Exploring the nature of PPS/initial goals for therapy	Case TN: Primary premature ejaculation (PE)	Case TG: Primary anorgasmia	Case SQ: Primary PE	Case BX: Primary ED
Predisposing factors	Child sexual abuse as a teenager	Childhood emotional and physical abuse by father continuing into adulthood	Experience of sexual rejection as an adult during previous marriage	Childhood loss of father, surviving parent emotionally invasive into adulthood
	TN(1)Ref 8 Pt: I've in the past had some counselling because I was abused as a child sexually	TG(3)Ref 11 Pt:..he was just such a tyrant TG(3)Ref 14-15 Pt:..if you're a good girl maybe you can have this carrot but at the same time he would be beating you with a … stick	SQ(1) Pt:…erm I suppose during my marriage I felt rejected	BX(1)Ref 63 Th: Mental health health, low periods? Pt: No, apart from my father dying BX(1)Ref 22-23 Th:..you recognise it's never really been 100%, to explore how that's been going on? Pt:.. I've never been a really confident person sexually
Precipitating factors	Flashbacks triggered by recent event	Probing of recent partner	New to dating after divorce	Recent life-threatening conditions
Theme 2 cont.	TN(1)Ref 12-15 Pt… for whatever reason that brought it home to me to the point to where I was really struggling to sleep and so that was the thing that made me go and get some counselling and ultimately report it TN(1)Ref 23-26 Pt: I was having flashbacks, feeling pretty rubbish erm yea	TG(1)Ref 14 Pt:..it's not like that for everybody. But he questioned this a lot, he was probing	SQ(1)Ref 1-2 Pt:..back on the dating scene I suppose. And I suppose my first early experiences of getting intimate and not really being able to perform	BX(4)Ref 1-2 Pt:.. very low grade BX(1)Ref 9-10 Pt: so after going to the GP and two years before that since that point, are, the medication I was given for the … condition in effect seemed to make things worse

Perpetuating factors	Not telling, sense of shame, protecting self/others	Covering up, not telling, protecting self/others	Not telling, keeping busy, avoiding, protecting self	Not talking, covering up, protecting self/others
Theme 2 cont.	TN(1)Ref 23-26 Pt:…it took me so long to tell her TN(1)Ref 27-28 Pt:…that was I think a sense of shame and of wanting to protect my family from other people knowing about it and I guess protect them from this person TN(2)Ref 13-14 Th: What did you think of you? Pt: I think somehow, for the most part I kept the two very separate…	TG(1)Ref 55-59 Pt: I feel like it should I should be getting more out of sex. If I got what I pretend to get TG(4)Ref 5 Pt: so I try to be nice I try very hard for his approval	SQ(1)Ref 8-10 Pt: I probably thought, well I'll just get through this without having to speak to anyone SQ(1)L564 Pt:… I probably spent more time on work wise, keeping busy.	BX(1)Ref 15-16 Partner: I think you would be prepared to say, for many years, this was something he didn't want to talk about BX(1)Ref 48-53 Pt…if I'm not warm then, to be honest you don't feel like sex and therefore during this … period - it's like a hibernation type effect. Th: so that, so there's no intimacy at all? Both: Sometimes for months, yes
Nature of PPS complexity Theme 2 cont.	Secondary erectile dysfunction (ED), loss of orgasmic feeling	Choosing unsatisfactory partners, sudden loss of feeling	Secondary ED, loss of arousal even with medication, loss of feeling	Loss of connection between thoughts and arousal, hesitance
Linked emotion	Frustration, despair, cut off	Involuntary loss of feeling, despair at injustice	Anxiety	Involuntary loss of feeling, frustration, anxiety
Theme 2 cont.	TN(1)Ref 1-2 Pt:..occasionally it is that I can't get an erection References 53-55 Pt:..I can't really be bothered because knowing what could happen and that it is not	TG(1)Ref 10 Pt:..I just blank off Th: blank off? Pt: I don't know, I'm just a good actor, because nobody has guessed.	SQ(1)Ref 18-21 Pt:..got to a point in the last 12 months. I've really struggled. You know, not getting an erection at all	BX(6)Ref 1-2 - Pt:..Because it's almost like losing concentration, thinking, okay change something with regards to what I'm doing in relation to my partner and therefore the consciousness is not on me, that then starts to alter me and then in me, in my brain

	going to be as fulfilling as I'd like	TG(1)Ref 28-29 Pt: so all the lead up to it all the arousal is pleasurable and then I don't know, then there's a point in it when I just totally don't see, don't feel, don't experience, just goes – those emotions. TG(4)Ref 1-4 Pt:..is it just me, or is it just not meeting the right people… like I have got low self-esteem because of the way… you know I feel I'm being unjustly treated you know	SQ(1)Ref 28-30 Pt:..I need to take a tablet now because I'm going to be in the situation where I cant perform. And then I've sort of taken the tablet and it hasn't really done anything. SQ(1)Ref 39-40 Th: And any current medication? Pt: The only medication I take on a regular basis is the O…, which is for heartburn	– okay, it's going, that's it. It's gone. (Clicks fingers). BX(2)Ref 11 Pt:..again sometimes, sigh, it's this in the back of my mind it's, are things going to happen? …Pt:..and if things don't happen to me it's just a vicious cycle of, you know a complete negative loop that you get into
Initial goals	Greater satisfaction through improved function	Greater satisfaction through relationships	Greater satisfaction through improved function	Address anxiety to improve function
Theme 2 cont.	TN(1)Ref1-2 Pt: I want to resolve it whether that is related to the abuse or not. TN(1)Ref 3-4 Pt: Yea to improve it – more often, longer, more satisfying for both of us.	TG(1)Ref 2-3 Th:..what would be a good enough goal for your sexual life…? …Pt: it doesn't have to be orgasm, just to be fulfilled …Th:.. generally, and for sex? Pt: yes I don't want to get… go through my 20s again	SQ(1)Ref 1-2 Pt:..my preferred outcome, one is to resolve the problem why I'm not getting a hard erection References 3-4 Pt: And the second one would be, what can I do to feel more confident and comfortable enough to last longer	BX(1)Ref1-2 - Pt: I would like to be able to initiate sex without having any thoughts, any pressures of, 'Am I going to achieve an erection and maintain it?'

Theme 2 see above

Theme 3: Therapist Reflexivity (therapist noting areas to be addressed): distilled content

3.Therapist reflexivity				
Defending and protecting	Not talking	Involuntary shut-down	Important to convey wellbeing to others	Loss of feeling
TG(2)Ref 11 Pt: ..because if I make the choices I make them to keep me protected TN(2)Ref 1 Pt: If I tell my mum and dad, but then it goes public and not really caring for me, but caring that the impact that could have on them	BX(1)Ref 1 Partner: …for many years, many years this was something he didn't want to talk about SQ(1)Ref 4 - Th: were you able to talk about it together? Pt: Not really, no.	TG(1)Ref 1 Pt:I just blank off Th: blank off? Pt: I don't know, I'm just a good actor, because nobody has guessed. From exploring the Nature of PPS higher extraction: BX(1)Ref 48-53 Partner: during the …period - it's like a hibernation type effect. Th: so that, so there's no intimacy at all? Couple: Sometimes for months, yes	SQ(1)Ref 1 Pt: I just felt…I'm quite mentally quite strong, you know BX(2)Ref 2 - Pt: I tend to sort of come out of things fairly quickly. TG(3) Ref 2 - Pt: I know I'm a good person, I do know I am worth it, I am good	TN(2)Ref 4 Pt: I don't feel really feel that I feel anything. SQ(1)Ref 5 - Pt: I'd moved on, so, yea, I didn't really feel too much of it

Theme 4: Use of symbol and metaphor: distilled content

4. Use of symbol and metaphor	Therapist initiating joint expansion of meaning	Pt. initiating expansion of meaning for therapist	Used to challenge and to precipitate action	Potential for returning to metaphor
	TG(1) Ref 5 Th:..Like an object or a shape? Pt: well at the moment everything is like Magnolia (laughter) Th: and you would like it to be what? Th: orange (laughter), orange! TN(4)Ref 1 Pt:… I can't capture the essence of it in my mind in a word. Th: Are you seeing something in your minds eye? a picture? Pt: No, not a picture, it's more a, it's not well-being. It's not confidence, it's not contentment. It's kind of all of those at the end of sex, just a lifting of because I guess it's deflation of spirits, just a lifting of spirit	BX(2)Ref 2 Pt: if I can get over one particular bridge then I'm all right. if I don't get over the bridge then I'm, that's it Th: I – and the bridge is what, in that setting? Pt: basically obtaining the erection TG(1)Ref 1 Pt: it's like, a - like having a meal you're hungry and and you are dying for the food and you start to eat it and the taste buds go…	TG(6)Ref 1 -2 Th: So when you describe it as a cutting off it almost, for me, hearing you say that cutting off, it's like almost the ultimate punishment because here someone who is denied… Pt: But they don't know! Reference 2 Th: So you cover it up and it starts again, who is the loser here? BX(7) Ref 2 Pt: if there's another way round it I would rather do that than… Th: But you pay a price?	TG(2)Ref 1 Th: You use some colours last time. What colour would these be today if you could get there and we are working towards you getting there… What colour would you say these are? Pt: Very pale.

Theme 5: Sensitive Attunement: distilled content

5. Sensitive attunement				
Reflexive interpretation	Acknowledging pain and distress	Accepting the subjective view, use of pt's own words	Looking at wider patterns of response to life situations	Linking the wider patterns to the sexual PPS
BX(2)Ref 1 Th: more recently, I felt a sudden sort of, how can I say the word, what's this word, as sort of shocked response, Pt: Right, Th: a shocked response in the way that I heard that story, Pt: OK Th: those 2 stories and it sort of, gave me a sense of okay what was this like for you? Pt: Right TG(4)Ref 8 Th: And I think that's not fair, that's unjust, why should you have to be in this situation? Pt: I can't make any sense, I don't know	BX(2)Ref 2 Th:– ok, so you still carry that sudden loss in your body? Pt:– yes, absolutely, so there is not a day, there is not a day goes past where I don't think about him TG(6)Ref 4 Th: The whole story is of a tremendous strength that you have shown, but also of tremendous hurt you have been carrying all these years. Pt: (Tearful)… Th: And it's gone around and around and around... SQ(3)Ref1 Th: Yes, so you were carrying quite a load weren't you Pt: Yeah Th: Actually Pt: Yes yes Th: Inside you	TG(2)Ref 9 Pt: but I will go all out to be your best girl Th: (quietly) yes, okay. Yes, that's sounding like a younger you, 'to be your best girl' was that to mum or dad? Pt: (tearful). I don't know but I never really achieved it. BX(5)Ref 2 Pt: Yea okay I don't think there will be anything gained in preparing them, I don't think there will be any difference in reactions, feelings, if nothing was said, compared to if something was said. Th: okay	BX(7)Ref 1 Th: what I'm hearing is, for fear of loss, whether it's loss of somebody else, or whether it's a loss of mum's love, whether it's loss of your love for your mother. […] going around the edge in order not to risk a form of loss – would you say? Pt: yes, I would say that's a perfectly valid and accurate thing. I do go around things TG(3)Ref1 Pt: something that is unachievable. I am who I am. Th: But you talked about quite difficult circumstances that you grew up in Pt: Mmm Th: And maybe ways which you'd adapted yourself Pt: Mmm Th: To the circumstances, self-preservation Pt: Yes	SQ(1)Ref 3 Th: But at each stage you're not talking. It's hard to talk through Pt: Yes Th: What's actually going on Pt: Uh huh TG(3)Ref 9 Th: So when when I remember you talking about a time in your … growing up that you felt very empty inside, did I hear that right with the sexual relationships? Pt: Still Th: An emptiness, has that always been present? Pt: Yeah Th: Even when you were in a good time with your husband? Pt: Yeah yeah

Theme 6: Facilitating expression of emotion: distilled content

6. Facilitating expression of emotion	Clarifying and validating present feeling	Exploring past feeling	Finding internal conflict	Acknowledging previously unacceptable feeling or fact
After this the theme is renamed 'Validation of Emotion'	BX(1)Ref 1 Th: when you say quite angry about it- how angry? BX(1)Ref 5 Th: what was that like for you? Partner: it felt very rejecting SQ(1)Ref 2 Th: And what for you - what has that been like? Pt: it's absolutely. Just dejected, you know. TG(1)Ref 4 Th: what is the feeling you're getting right now? Pt: (choked speech) – right now I'm just feeling embarrassed	TG(1)Ref 3 Pt: But a part of me is searching for something… Th: longing? Pt: yes, yes – frustrated because I know I should be… Th: is that feeling similar to a feeling you had when you were younger? Pt: yes Th: longing for something, looking for something? Pt: yes, and that's what's coming back (tearful) TN(2)Ref 9 Th: When you think of it in reference to yourself, what is the emotion? Pt: I just kind of think it's happened and it was unpleasant and is something that times I thought I'd resolved and it turns out that I hadn't SQ(1)Ref 9-10 Th: What was that like? Pt: Erm, I think yea initially it was anger	TG(2)Ref 2 Th: we look at the physical as it is, as well as the emotional Pt: I think that's what I'm scared, of being looked at emotionally TN(2)Ref 3 Th: Was he a man that you liked and admired particularly? Pt: He was quite a bully in some senses and… There was kind of a bit of a sense of as a physical sensation that it's nice SQ(1)Ref 5 Pt: initially it was anger, you know SQ(1)Ref 6 Pt: on the flip side of it, I was quite relieved as well BX(2)Ref 14 Th: so what was that like for you being between the two of them? Pt: sometimes difficult and frustrating	TN(4)Ref 1 Th: […]and your partner is angry and demanding…? Pt: I think that's probably something that's has been a theme TG(4)Ref 2 Pt: Well I wish he would die Th: Yeah Pt: And I've wished that for a long time BX(6)Ref 6 Th: well what if what if I didn't make it through this? Pt: I'd be pretty hacked off. (laughter) SQ(1)Ref 5 Pt: initially it was anger, you know but I again didn't really talk about it with anyone

Theme 7: Developing cognition in relation to the emotion and the PPS

7. Developing cognition in relation to emotion and the PPS	Making conscious through acknowledging & accepting emotion, through information sharing	Developing awareness	Tracking back through past experience	Wider life examples found as parallels to the PPS
	TG(1)Ref 2 Th: So there's a lot of pain there around this stuff Pt: (tearful) again, I feel embarrassed, (tears) Th: again, thank you for showing me your upset with this, because this is crucial, really, to our work	TG(1)Ref 1 Pt: I'm feeling judged by myself	TG(1)Ref 3 Th: who says you are not nice? In your world? Pt: nobody says that, nobody says that (tearful) but nobody says I am either	TG(1) Ref4 Pt: I couldn't risk it couldn't risk going for it just in case I didn't get it. Th: again you're telling me something very important that we can use in our work together understanding how you reacted in that situation Pt: it's the rejection the fear of rejection

Theme 8: Behavioural interventions and responses: distilled content

8. Behavioural interventions and responses	Making sense of elements possibly contributing to PPS	Recognising contradictions & consequences	Challenge to patterns of response	Recognising blocks to change
Contributions from Sensitive Attunement higher extracts: Addressing 'automatic thoughts' and behaviours	BX(2)Ref 3 Th: because I went back there as sometimes- it, it can be that it is something that has happened early on that somehow affects sexual function. It's a bit mysterious until Pt: yes Th: we just start to lay it quietly, out there- and so you let me witness today the feeling that, that sudden-death is still inside your body as a body memory of a disaster happening TG(2)Ref 8 Th: but as an adult we can't expect someone else to give us a total value. Pt: You say can't but it's a tough call for us to do that Th: yes, yes, because if we are expecting it from someone else, we are always going to be let down, always because they're not a parent to us. They are an adult, ordinary human being. (Laughter.) Pt: Yes, yes, which is why I think I do have relationship problems	TG(4)Ref 3 Th: Okay and when you came at first here you said to me very sadly, I don't want to have to go back to how I was Pt: Because I'm searching for something and I know I'm looking in the wrong places TN(5)Ref 3 Th: you were already protecting or conscious that somehow you needed to protect them from it. Pt: Yes Th: that you didn't need help? Pt: yes I felt at the start but that as time went on I would have welcomed help, but other fears probably stopped me from stepping out.	SQ(1)Ref 1 Th: So you wanted not to experience the embarrassment that that meant then Pt: Yea, yea Th: Switching the sex off? Pt: Yea, yea, BX(4)Ref 2 Th: Because I'm thinking symbolically as well as your vessels closing down Pt: Yeah Th: And the whole of you shuts down to your emotional self and we're in the process of opening up now Pt: Yeah	TN(6)Ref 3 Th: And it is interesting, the feeling of orgasm as well, that you're getting at – it's like you're owning it – allowing it, or…? Pt: Mmm Th: And I wondered whether part of our talk might have released some of that, having walked around that early life experience? Pt:Yes, well I guess it made it less, I don't know. BX(4)Ref 1 Pt: let's try, you know, intercourse but not being able to because of what's going on in the back of my mind sort of thing, fear of hurting her, so. Th: Okay, so a fear of hurting her Pt: yeah yeah because I don't… Th: Yes yes. So that would be a concern to you

Theme 8. Cont. Patient facilitation of behavior changes	Medicines with side-effects	Medications for physical dysfunction (PSS)	Follow-through & seeing results	Blocks to making progress
Self-initiated	SQ(2)Ref 2 Pt: I stopped taking the tablets (O…)	SQ(2)Ref 7 Pt: I didn't take a tablet and it was okay	TN(3)Ref 1 Pt: I want to give it a go because I wanted to work as a whole process SQ(3)Ref 3 Pt: the only thing I'll do next is really the exercises BX(4)Ref 2 - Pt: and try to incorporate that TN(4)Ref 1 Pt: So I did the exercises intermittently when I did, sex was better TN(6)Ref 1 Pt: being a bit more consistent with that seems to have worked a treat.	SQ(3)Ref 1 Pt: don't really have time at home BX(7)Ref 2 Partner: it has been incredibly busy BX(4)Ref 1 Pt: touching anywhere is painful BX(5)Ref 1 Pt: the tablets sort of thing to be honest didn't work. BX(5)Ref 2 Th: also the vacuum device, have you tried that? Pt: Yea, we sort of talked about things like that but I just think you know, it's impersonal

Theme 9: Developing Experiential Change distilled content

9. Developing experiential change	Facilitating cycles of self-awareness:	Developing confidence through goal assessment reviews	Changes in ways of doing through goal focus	Growth in self-awareness
Impact on partner BX(6)Ref 1 Partner: He would quite often say he wasn't in the mood, but he never says that now. TN(6)Ref 3 Pt: she said recently, grateful that I have done this SQ(3)Ref 1 Pt: things have actually been going really well	SQ(2)Ref 1 Pt: …I felt rejected TN(2)Ref 3 Pt: my desire is dependent on how it went. BX(1) Pt: …sexual shut down for 3-4 months every year TG(7)Ref 5 Pt: If I didn't get it, I couldn't stand the rejection.	TN(3)Ref 7 Pt: less disaffection BX(3)Ref 7 Pt: I feel less worried SQ(2)Ref 4 Pt: psychologically I can forget that past and think everything is fine now TG(7)Ref 1 Pt: it's bought my self-esteem up.	TN(2)Ref 1 Pt: why don't we try to do something about that SQ(2)Ref 7 Pt: I didn't take a tablet and it was okay TG(7)Ref 2 Pt: It's made me question BX(3)Ref 2 Pt: We took things slowly	TG(7)Ref 4 Pt: I think, be all right if I didn't get it, whereas before I was scared to go for it. TN(5)Ref 1 Pt: I have been conscious. It was a bit a bit of a kind of a faltering start SQ(2)Ref 5 Pt: the confidence and everything else got the better of me BX(3)Ref 8 Pt: I didn't get completely wound up

Theme 10: Checking for acceptability of the intervention distilled content

10. Checking for acceptability of the intervention	Talking	Changing perspectives	Negative/ positive feelings	Reviewing/ Celebrating
	BX(2)Ref 1 Pt: we'd started to address things, talk about things, SQ(3)Ref 1 Pt: talking things through has really helped TG(7)Ref 1 Pt: I can talk quite freely and openly to you TN(6)Ref 1 Pt: …a positive thing to do	SQ(3)Ref 3 Pt: I would have become more and more apprehensive about it and things wouldn't have gone the way it has with D TG(6)Ref 1 Pt: making me rethink BX(7)Ref 2 Pt: It's been interesting to pick out situations or ideas that I didn't think had anything to do with the situation I am in	BX(1)Ref 1 Pt: a lot easier much more relaxed than I thought BX(2)Ref 2 Pt: just felt pleased about coming SQ(3)Ref 5 Pt: at the beginning I was quite sceptical TG(7)Ref 2 Pt: it's bought my self-esteem up. TG(7)Ref 4 I used to hate coming	SQ(3)Ref 2 Pt: baggage I've been able to let go SQ(3)Ref 6 Pt: I think the outcome probably speaks for itself really BX(6)Ref 1 Partner: that was a huge advantage of coming here TG(6)Ref 2 Pt: I'm much happier with things now TG(7)Ref 5 Pt: I could see it happening again and I think if I hadn't come here I think it may well have done.

Open coding continued from Chapter 7.3:

iii) **Reflecting back: therapist response to what is said**

Means of engagement:

- registering emotion
- expanding a felt sense
- what is the feeling you are getting right now?
- tentative reflection
- amplifying meaning
- use of patient words to expand meaning
- keeping the focus

Verbatim examples (A-U):

D) *Th: are you seeing anybody else for any therapy at the moment?*
Pt: no no, I was seeing somebody about our grieving counselling but I didn't need to. I think that it's okay to be sad when someone has passed away, …. I feel, I wouldn't say that I'm depressed but I do feel fed up sometimes. And fed up that … And fed up that I've had to come here today. I'm fed up that …, fed up that …, you know.
E) *Th: And what, for you, has that been like?*
Pt: …it's absolutely. Just dejected, you know
F*) Pt: that's what I suppose I mean by fulfilment – the connection thing*
Th: something about connecting?
G)Th: so how was that for you?
Pt: Erm, at that point…I'd moved on, so yea, I didn't really feel too much of it…initially it was anger, you know, but again I didn't really talk about it with anyone

Outcome: **Expansion and amplification of the quality of distress**

iv) **Encouragement to continue**

Means of engagement

- Taking it back again to when it started
- What was going on for you at the time?
- Follow through on what is described
- Expanding therapist understanding
- Exploring the relationship to the PPS - self and partner

Verbatim examples:
H) Pt: …but it's just… Like a big part is missing (becoming tearful again) and I just feel like it's going to affect me (stronger voice) mentally (laughter), well it will
Th: in what ways have you noticed already?
Pt: thing is I feel that my right has been denied me but I'm the one doing the denying...
Th: or it appears as if…
Pt: well it's not as if it's anybody else
I) *Pt:…even if I'm not even with my girlfriend I'm not generally getting*
Th: Those erections at other times?
Pt: Yea
Th: I'm just going to take you back again to that first time,…

Outcome: **A gradual recognition of precipitating and perpetuating factors**

v) **Taking a brief medical and social history**

Means of engagement

- Exploring organic causes
- Physical response to illness, to medication, to treatment
- Current relationship to the PPS
- Current relationships and the PPS
- Glimpse at early life experiences

Verbatim examples:

J) Th: Right, erm, okay so that side of thing. And then the [medication] O…e has been known to cause sexual difficulty
Pt: Oh really
Th: Erectile problems
Pt: The O…e
Th: Yes
Pt: Oh right
Th: Erm and so we've got this pattern haven't we, you're saying your erections aren't as secure
Pt: Yea
K) Pt: …I did have a really bad time and I went about depression (tearful) but I never took the antidepressants
Th: so you were offered?
Pt: yes, but I never took them, I only took one and I did feel better but the doctor said it couldn't just, couldn't possibly have been one [tablet] that made me feel better. It was just a very tense time
L) Th: did he drink as well?
Pt: no no, he just worked hard and he wasn't really there much. He worked hard.
Th: and that bad temper how did it affect you?
Pt: was unreasonable (laugh) and then he would buy you something nice, once the temper had gone
M) [re.sister's divorce]
Pt: …that happened in the second year of my marriage, so we were living at home at the time with the parents, so that's probably why the period…

Th: was a bit stressful for all of you?
Pt: yes, yea, and err and it probably explains some of the reasons why between year 3 and 6, I wanted to still carry on and make our marriage work
Th: Yes
Pt: So a bit of pressure, didn't want to take the family through it again

Outcome: **Developing growing awareness of potential predisposing, precipitating and perpetuating factors to guide the direction of the intervention**

vi) **Linking thought and feeling to the body's PPS**

Means of engagement

- Bringing the whole person in to understand the PPS
- Amplifying this feature
- Recognising what perpetuates the PPS

Verbatim examples:
N) Pt: ...Because I feel I'm not connecting with people I, not feeling the love
Th: so now you are asking, where is the love?
Pt: to put up with, as I did with my husband
O) Pt: And I was feeling this isn't going to be long term anyway. And secondly yea that the sexual side petered out a bit anyway
Th: Okay so two messages coming through to you.
Pt: Yea
Th: And and after that did you try again, or was that it then
Pt: Yea that was it, apart from that I didn't really get close to anyone else who I met

Outcome: **Greater sense of unique story/situation and breadth predisposing or precipitating factors**

vii) **Challenge to expand awareness of the nature of the PPS by use of metaphor**

Means of engagement

- What if….
- It is as if….

Verbatim examples:
P) Pt: And that was my sort of get out
Th: Your plan (laugh)
Pt: That was my sort of plan
Th: I wonder if she found them [tablets], found out what they were for
Pt: Erm I'd tell her obviously
Th: So it wouldn't be the end of the world if she
Pt: No
Q) Pt: … instinctively I know but I don't know how to word it
Th: so if we could think of it in another way, like a picture of how it is now… and may be a picture of what you would like to experience? Would a picture come to mind? It's like this now and I would like it to be like that? Like an object or a shape?
Pt: well at the moment everything is like Magnolia (laughter)
Th: and you would like it to be what?
Pt: – orange (laughter), orange!
Th: Magnolia to Orange we should write that down (laughter)! Okay

Outcome: **Challenged regarding potential perpetuating factors i.e. hiding/protecting self, indicating by metaphor of colour, growth of patient and therapist awareness that the PSS is linked to the whole of life, also later discovered to be hiding/protecting self with the PSS**

viii) **Giving information**

Means of engagement

- Explaining the service
- The model of working
- The use of questionnaires
- Responding to requests for practical suggestions

Verbatim examples:

R)*Th: Okay. So the purpose of our work here, we take full consideration of physical issues and underlying always keep that in mind. But also, looking at the whole person and their environment and what's been happening too. So often it's the combination of those things, … and then we work with what appears to be relevant. So I won't know at the outset what's relevant until we have a look around, and see where there's something we can work on that would help to get you to where you want to be*

Pt: Fine

S*) Th:… Let's say if you did want to, if you did, I would be offering you six follow-up sessions. They are just once a month and we have a six-month period so that's a good amount of time to work through issues that we have the potential of working through here. And for some people, they don't need that many as things click into place for them and that can be a mystery. Some people need more time and we can negotiate for more time if you need it. We don't just meet for the sake of it.*

Pt: No

Outcome: **Continued engagement to this point**

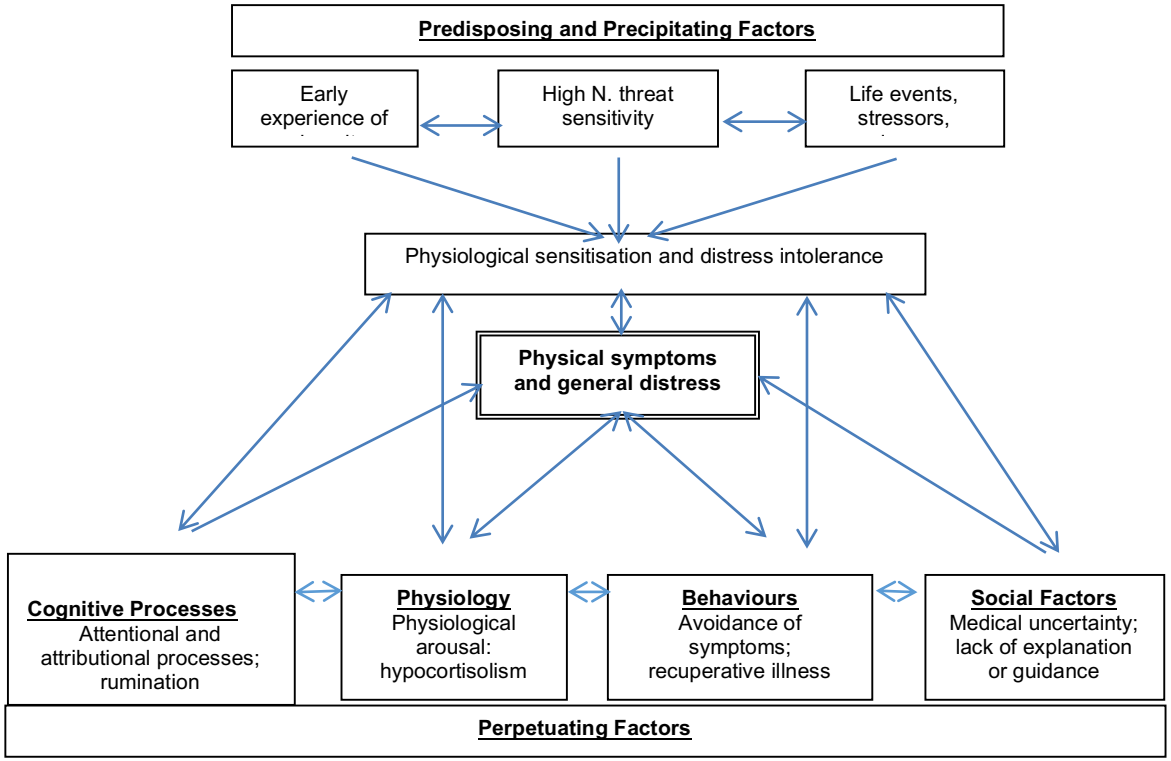
ix) **Developing and evaluating goals**
Means of engagement

- What would be realistic and good enough to walk away with by the end of therapy?

Verbatim examples:
T) *Th: Okay. So we have got a number of strands here to work with*
Pt: Okay, good
Th: I'm just thinking about where we should start with that. And I guess, what would be the upper most thing, what do you want to address first?
Pt: Erm, the first thing I do want to address is, would be to get a hard erection,
Th: Okay to restore the erection
Pt: Yea yea
U) *Th: we meet for a purpose in order to work towards something so I need to ask you now, what would that something be. If we thought of it in terms of a goal, what would be a good enough goal for your sexual life to come away with, or for your sexual self?*
Pt: it doesn't have to be orgasm, just to be fulfilled
Th: to be fulfilled is that a general term as well for you?
T: yes yes
Th: generally, and for sex?
Pt: yes

Outcome: **Therapist enabled to work directly to Pt's felt needs rather than by therapist presumption. In order to reach final goal, preliminary goals suggested by the individual are discussed and developed further and found worked on in subsequent sessions.**

Appendix 17: Expanded CBT model of hypothesised autopoetic cycle (Deary et. al. 2007)



Suggested enhancements to the Expanded CBT Model of hypothesised autopoetic cycle of symptom perpetuation:

The Reflexive Insider-Realist Service Evaluation findings suggest further enhancements to this model (Deary et. al., 2007) for non-ruminating Unremitting and Unresolved Symptoms (UUS) to include the disabling of PPS factors:

Following are the Expanded CBT model's Predisposing and Precipitating Factors:

1) Rather than 'Physiological sensitisation and distress intolerance' linked to 'Physical symptoms and general distress' a suggested adjustment from the ri-RSE findings to 'Physiological sensitisation to threat perception' (often below the level of conscious awareness) linked to 'Experience of Unremitting and Unresolved symptoms'.

2) The inclusion of unprocessed, unacceptable emotion within 'Perpetuating Factors'

3) An added cycle of cross-therapy modality guiding principles for disabling the predisposing, precipitating and perpetuating mechanisms of non-ruminating PPS (Fig. 8.)

Appendix 18: A guiding matrix for cross-modality therapeutic engagement with PPS

Themes	**Content**				
Engage the Therapeutic Alliance	Generate hope	Give and get information	Invite to expand on story	Develop the patient-therapist partnership	
Explore the nature of PPS/PPP & initial goals	Scan for potential predisposing factors (P)	Discover precipitating factors (P) (What brought you here/how did it start?)	Understand the detailed nature of the PPS complexity (How and when does it happen?)	Develop awareness of perpetuating factors (P) (What blocks recovery?)	Value linked emotion (Does the PPS still have a purpose?)
Use therapist reflexivity	Observe for loss of feeling	Reflect on presentation of patient self	Observe involuntary shut-down	Note defence and protection of self and other	Note the extent of not telling
Use symbol and metaphor	Initiate joint expansion of meaning	Embrace the person's expansion of meaning	Use symbol and metaphor to challenge	Return to metaphor for expansion of meaning	
Act with sensitive attunement	Acknowledge pain and distress	Accept the subjective view and use person's own words or examples	Look at wider patterns of response together	Explore any link from the wider patterns of response to the PPS	Use therapist self to mirror the impact on self and others
Validate emotion	Clarify and validate present feeling	Explore past feeling & any previously unacceptable fact	Engage reflexively with any internal conflict		
Develop cognition relating to emotion and the PPS	Acknowledge & accept emotion	Develop awareness of individual self and others in relation to the PPS	Listen to past experience	Observe responses to wider life examples	Find the core hurt
Trial of person-matched behavioural interventions, note responses	Agree PPP factors that may contribute to the PPS to match to behavioural interventions	Recognise contradictions & consequences relating to what is said and what is done	Challenge patterns of response	Recognise blocks to change	Value both person readiness or non-engagement
Develop experiential change	Facilitate cycles of self-awareness	Make changes in ways of doing through goal focus	Develop confidence through goal assessment reviews	Validate what works	Find out with the Pt. what they need next
Check acceptability of the intervention	Ask how the intervention is being experienced	Acknowledge personal perspectives, respecting need for further change	Give non-judgemental space for the expression of negative and positives	Review focus/ Celebrate change, recognise 'good enough'	Agree how any remaining work will be done

Appendix 19: Remaining Therapist concurrent reflexive memos TG Tables 8.iv), TN Tables 8. v) and BX Tables 8.vi)

Table 8.iv. Participant TG(1): Dynamic reflexive memos
(PSS = Persistent Sexual Symptom)

Participant ID & session no. ( )	What?	So what?	Now what?
TG (1) Anorgasmia	Why is TG so distressed returning to repeating the patterns of her late teens, early 20s?	This distress may be a key to her PSS.	Needs further exploration.
	TG is showing signs of ambivalence about attending	What is this ambivalence about for TG? Eg. If I were a man I would have come for help years ago. I am a woman, I put up with this.	Why is she making this contrast between men getting what they need, demanding it and women keeping quiet, putting up with it. Is this a glimpse of predisposing factor? Needs further exploration.
	Sex is magnolia or grey, Dad is grey. Children are peach.	Magnolia to orange is her preference for change	Use of metaphor gets us nearer to the heart of the matter? Something to do with father and sex?
	When TG shows upset, she feels embarrassed, ashamed here.	In the moment, I feel taken aback: when given careful attention, TG feels worse.	Where does this originate from? Does this link to her PSS and reactions to others/to intimacy?

Table 8.iv. Participant TG (2)

Participant ID & session no. ( )	What?	So what?	Now what?
TG (2)	TG Feels confused.	Feeling loss of control, feeling fear in therapy?	I am alerted to fear of unwelcome invasion or is it fear of exposure or criticism? Plan: Reflect back to TG.
	I give her structure to reduce the high emotion by focus on and forming goals together.	Aiming to relieve confusion and distress, to get back to what she says she wants.	Will this help grow trust and safety in which to work?
	Fear of rejection. Cannot risk going all the way (to apply for new jobs) TG feels it would be the end of her world- better to avoid the risk.	Is this response linked to her sexual experience in some way? Could the fear of rejection and exposure be a perpetuating or a pre-disposing factor for the PSS?	Explore lack of orgasm-what does this mean for TG relationships? Plan: Explore relationships.
	Removes herself from social situations.	Feels sad.	Feels angry because no-one has noticed she wasn't there, no-one asks her if she is alright-is this linked to early life relationships?
	I will go all out to be '*your best girl'*	'to be your best girl' sounds young. *Pt: I really need your approval, even if you haven't got mine. I desperately need your approval.* *Th: And you will work for it?* *Pt: Yes and then I won't get the approval that I need and then I'll be disappointed with you and I will walk away, but I will go all out to be your best girl.*	Another indication of early life hardship? TG is not telling me directly about the source- What/who is she defending?

Participant ID & session no. ( )	What?	So what?	Now what?
Cont. TG (2)	*Pt: I am nice but I have no-one. They are not nice but they have so many people who like them.* *Pt: My children: They're big and intelligent and are nice people and they still like me. It helps*	It seems hard to value self: bewilderment, anger, sadness Pattern of response: If I am nice I will be valued. If I am not valued I give them no respect and I cannot respect myself Here is a need to please to find value, but strong defence against being let down and yet she repeatedly experiences let-down.	Is the picture of the PSS anorgasmia mirrored here? All seems to be going well but TG cannot afford to let go completely.
	Recognising her need for safety. As therapist I am doing as much as I can to provide a safe place	It is argued with, pushed away.	Does this get mirrored again in the lack of orgasm?

Table 8.iv. Participant TG(3)

Pt. ID & session no. ( )	What?	So what?	Now what?
TG (3)	Signs that TG is defending her parents. *Pt: That wasn't that bad either that was typical of being…that time of… people weren't as educated to children's emotional needs as we are now.*	What is this childhood like for her-what is she defending against others knowing/self knowing?	Find out what this means for TG.
	Pt: Yeah, yeah…so when I come here it sort of starts to make a bit of sense, but then when I'm not here I think why am I doing that… waste time, wasting loads of time *Th: Yeah, so that's telling me you don't think a great deal of yourself, like you're not worth it, you're not worth the time?* *Pt: I know I'm a good person*	Is the low sense of self-value causing conflict with the process of change, blocking attention to self? What will this mean for the progress of work here?	Stay with it-take it as it comes. TG may need a second therapy contract.

Pt. ID & session no. ( )	What?	So what?	Now what?
Cont. TG (3)	Pt is showing me a pattern of response.	Does this run parallel to the sexual experience as lack of orgasm? *Th: Yes, yes, so you're presuming in advance, you're going to be left high and dry* *Pt: Yeah* *Th: You're going to be* *Pt: I'll get there before you do* *Th: So you'll end it before they do* *Pt: Yeah and that's how it's always been*	Share the developing insight.
	At the end of the session able to say: *Pt:..so none of us have got a close relationship with anyone (laughs) not with each other either, quite dysfunctional family in a lot of ways.*	But still defending: *Pt: I think the thing that I'm scared of going back is sometimes I think I don't remember much of my childhood not much really and I think is there a reason why you don't remember much…* *Pt: I don't want to go back and uncover anything*	Respect TG's boundaries:

Table 8.iv) Participant TG(4)

Participant ID & session no. ( )	What?	So what?	Now what?
TG (4)	*Pt: I just don't know how to deal with injustice that I feel* Feeling injustice-needs to find a way of coping in the here and now linked to a current relationship fall-out.	We make links together back to father. Pt is able to let out how she feels: *Pt: Well I wish he would die* *Th: Yeah?* *Pt: And I've wished that for a long time* Beginning to acknowledge patterns of response and the cycles of hurt and pain	Frees herself, then falls back into guilt, she feels bad for having those feelings. Plan: Give her time, don't rush.
	Recently saw the treatment of her brother by her father: *Pt:..but he just gave him the cold shoulder like I saw him doing to me saying, what [do] you want, what business have you got coming round here? And I just sit there thinking I shouldn't have come, I shouldn't have come. I wish I hadn't come, I wish I hadn't come!*	Is this a link again, the parallel to why she is anorgasmic? Too dangerous, could open self to humiliation... Note the use of words which may have direct connection to the PSS, indicating the danger involved, *'I wish I hadn't come'.* *Communication through symbolic language perhaps just below the level of consciousness?*	Share this reflection. There seems to be a pattern, a cycle of movement forwards and then sudden spiral back. Hard to see and allow change for and in herself? Another indication that a second contract may be needed.

Reflection (5) was omitted as it contained little new material for reflection.

Table 8.iv) Participant TG(6)

Participant ID & session no. ( )	What?	So what?	Now what?
TG Session (6)	Changing responses to self and others. *Pt:...but she [I] was lost searching for the wrong things and I don't want to carry on making the same mistakes. So I think I'm not stuck and I think I have made some better decisions*.	Working with inner conflict. *Pt: I know the 1st 3 or 4 times I hated coming and not myself because I felt like I was coming because I was a failure. I just felt like I shouldn't be doing this, but I don't feel like that now feel more sort of like I'm just doing something that needs to be done. It's just something that's okay*	TG is following through with her changed perceptions, did not follow old pattern of response: *Pt: A couple of months ago I would have thought well, yes, I'll go and then I'll be even nicer and then if I'm nicer, if I'm really good it'll pay off and he'll be nicer to me to, so that was big!* *Th:...So you've allowed yourself, to give yourself respect?* *Pt:Yes* *Th: you have also, in a way given him respect* *Pt: yes I suppose so. I told him I wasn't happy with it.* *Th: So what have you avoided in doing that?* *Pt: I have avoided going into another toxic relationship! (Laughs). I have avoided setting myself up for a fall.*

Participant ID & session no. ( )	What?	So what?	Now what?
Cont. TG (6)	Growing a deeper cognition of underlying factors as to why this happens to her *Pt...I think I'm tolerant and forgiving, but maybe not subconsciously….* *Th: Perhaps your body follows through with that?* *Pt: Yes, with my last partner I would feel desire and I would desire him and I would feel turned on. That was never that I didn't want to have sex with him. But then partway through, I would shut down, with everyone I've ever known, really. I just cut off and go through the motions but to start with, I am aroused and up for it. I get to this point where I am numb there is nothing- I don't feel anything. I don't feel pleasure don't feel anything.*	As therapist I need to keep up the challenge to develop an even greater awareness of consequences to help her to decide what she wants to keep doing and what she is ready to let go of. Use my feeling response as a reflection on the outcomes of her patterns: *Th: So when you describe it as a cutting off it almost, for me, hearing you say that cutting off, it's like almost the ultimate punishment because here someone who is denied…* *Pt: But they don't know!* *Th: So you cover it up and it starts again, who is the loser here?*	How to move this cognition forward towards realising her end goal? TG is showing that she is taking on that insightful task herself… *Pt:..So when it comes to a sexual thing it is actually resentment that's there that I hold back. I don't give myself fully - I'm not only denying myself, I'm also denying them.*

Table 8.iv) Participant TG (7)

Participant ID & session no. ( )	What?	So what?	Now what?
TG (7)	From high positivity and positive change in all other areas, suddenly back to low estimation of self *Pt: Yes, it's really good!* *Th: so can we think about the last goal?* *Pt: To find satisfaction through intimacy well (laughter) it's no better! (Tearful)*	There seems to be ambivalence whether the issue is worth bothering with *…Pt:… It just tails off into nothingness- in a way I haven't had a huge problem with it …* *Pt:..it can't be them. It must be me. So yes, I would like to […]* *Th: but also you told me about a lifetime of searching for connection didn't you?* *Pt: Yes, it's been there for always.*	TG shows her need for physical as well as emotional connection and ability to reflect: *Pt: it was for myself in the sense that I would like to experience such a thing. And maybe there is something in me that is stopping…*
	Th: Is there anything we haven't covered that you wanted to cover? *Pt: I don't think so.* *Th: And do you feel it's okay to end today?* *Pt: Yes. I feel as if I would be wasting your time, do you think I would be wasting your time?* *Th: I want to take it [your need] seriously*	TG has resisted falling into any next relationship. This is a positive. All other goals met but the last has not been possible to test out yet with a new partner… But although so much genuine change has been reported, it seems hard for TG to say directly, 'I need more help' is this ambivalence again-not sure if she is worth it?	In the moment I feel it is important to offer a choice to TG rather than presuming I know what she needs. Take to supervision: This is considered as an appropriate ending. TG is free to return at a time of her choosing.

Table 8.v) Participant TN(3): Dynamic reflexive memos

Patient ID & session no. ( )	What	So what	Now what
TN (3)	Eager for a solution after the first session, the couple decided to have sex nearly every day	Can't sustain it *Th:… every morning, that drive, was it good for you…was it exciting for you both?* *Pt: No, I wasn't saying it was exciting it was pleasurable but I know I wouldn't say I was excited in the same way as since then. Since then, when we have had sex spontaneously it's been much nicer.*	Finding that their spontaneity is more pleasurable. Are they accepting more of each other, relaxing again?

Table 8.v) Participant TN(4)

Participant ID & session no. ( )	What?	So what?	Now what?
TN (4)	Recognising recently whilst reflecting on his PPS that a lack of good enough orgasmic feeling has been there for some months	Again I notice a lack of feeling too around the CSA-he says he felt great relief since reporting to the police, as if there is no further need to discuss its impact on him, but his wife can still be upset. Reflect on exploring this a bit further together as a couple. *Th: are you upset as well? Somewhere in there* *Pt:… I wouldn't say that I feel upset.* *Th: But you feel…[as you said] disappointed?* *Pt: Yes* *Th: and your other word, deflated?* *Pt: Deflated, Yes.*	Are these words TN used symbolic of his ED and loss of satisfaction without being conscious of the link? Is there any link back to unfinished business concerning the CSA?

Table 8.v) Participant TN(5)

Participant ID & session no. ( )	What?	So what?	Now what?
TN (5)	There seems to be a lack of feeling, and at times, responses that I am not expecting illustrated by his response to another child caught up in CSA…pity for the abuser *Pt: You might say…why not anger or being glad they're getting what's due them or anything like that?* *Th: So for you, it's pity, because…* *Pt: It's because…[for the abuser]… it got themselves into a situation where perhaps they don't want to be and where it's going to have significant implications for their life ….The only way I can describe it is that they aren't as they should be, which doesn't quite capture it…* *Th: That they can't help it?* *Pt: No, I wouldn't say that because I think you do have a choice how you act…… I can't think of it, I can't quite put my finger on it but that's how I feel. And yet can't quite explain it fully.*	Alarm bells are ringing. TN shows compassion for the perpetrator. Should I be concerned about future risk to others?	Take to supervision: Re. my concern over lack of expressed anger or empathy for a younger child in the same position- Perhaps he could allow himself to feel and express anger? Is this the key to restoring his sexual feeling? Plan: to see if it is appropriate to share this reflection in the next session

Table 8.vi) Participant BX(1): Dynamic reflexive memos

Participant ID & session no. ( )	What?	So what?	Now what?
BX (1) Couple	His partner is here to make sure I get the whole story-sometimes she says he forgets the details. There is a feeling of partner as strong and maternal plus evidence of BX's mother- invasive towards BX and to this relationship.	Where is BX, where is his potency in this account? Father died suddenly when he was in early adolescence. Some sense of 'near death' for me today as I listen … Where is his place of safety between two powerful, loving women? (plus myself as female therapist)	I have a strong physical sense of fear and fragility-where is this coming from? Plan: Explore who does this feeling belong to?

Table 8.vi) Participant BX(4)

Participant ID & session no.	What?	So what?	Now what?
BX (4) 1:1	I noted previously that the issue of a current investigation for potentially life threatening condition is not reported as a big deal for the couple.	Now able to say what a relief that the waiting is over and he can get on with treatment *Pt:…literally fingers crossed it's going to be done and dusted* *Th: Yeah* *Pt: and that's going to be out of the way sorted, forget about it, which has been a huge relief, effective for both of us, because it's been, what it's been, about six months plus where it's been hanging over us…*	Is there a pattern of diminishing the emotional impact of things? But when the future looks more certain, is it easier to allow recognition of stress?
Reporting feeling and function are returning	But BX still does not want to be the cause of more pain for partner *Pt: but the problem over the last couple of weeks has obviously been not with my partner, about not wanting to upset her back so to speak* *Th: so has she known that you felt that feeling?* *Pt: Yea* *Th: what has she said to you in reply?* *Pt: Basically, sometimes she's said let's not worry about that…*	Is this a pattern of not wanting to make things worse? Shuts down desire, 'the wanting', so nothing is challenged? Is this about loss of father and diminishing his own needs afterwards, trying to keep mother pain-free? Reflect this back in the session if indicated as a perpetuating factor.	BX reports that feeling and function are returning.

Participant ID & session no.	What?	So what?	Now what?
Cont. BX (4)	Found he was respected in the medical consultation. *Th: So they were respectful?* *Pt: Yes very much* *Th: You were thoughtful before, you are ready for a fight, you had support, and you followed through* *Pt: Yes…*	The medical encounter seems to have given confidence and hope. A form of potency…	Awareness of his sensitivity not to cause more pain or upset is growing. Easier to face challenge with wife's support. Finding greater confidence and hope at all levels.

Table 8.vi) Participant BX(5)

Participant ID & Session no. ( )	What	So what?	Now what?
BX (5) 1:1	Partner seems to be experiencing her back pain as a PPS.	BX gives this as the reason for lack of sexual intimacy.	What is being avoided?
	Life death issues arising again felt in the session– I wonder if he has talked to his family, to prepare them for the treatment not working?	Does not want to put it into their minds-But isn't it in their minds already? *Th:..you're considering their loss if something did happen?* *Pt: Yea okay I don't think there will be anything gained in preparing them, I don't think there will be any difference in reactions, feelings, if nothing was said, compared to if something was said.* *Th: okay* *Pt: I don't think, yea, that's what I think, I don't think it would be any different*	What is the fear here? Life/death? Talking about it? Invite his partner to session 6 for review on progress

Table 8.vi) Participant BX(6)

Participant ID & session no. ( )	What?	So what?	Now what?
BX (6) Couple	Partner describes his mother generating a thunderous cloud as a powerful communication of displeasure *Partner:..she sucks all the pleasure out of life, it's as if she sucks every ounce of it, she sucks it out of the room, sucks the life out of BX, and he becomes silent when she's like that….as if she takes everything from him.*	Partner is also aware that she cut in to a recent encounter with his mother and in effect prevented BX from confronting his her with his anger at her interference in their affairs. Is this why he has to focus on the woman, to reduce upset. If mother is upset he cannot be potent ie follow through with his own needs? Again, is it safer not to have any desires...?	Two strong-willed women who care deeply for him…BX has to be alert –and acts as if it is better not to disturb or be disturbed…is this why he is unable to maintain the erection, aside from his other medical problem?
	Conflict also for partner-wants to have sex but doesn't want to cause him pressure and distress *Partner: I have almost, because it's so loaded. I've almost wanted to back away from it and I don't want to do that. I don't want to make him unhappy frustrated and stressed, but I do want us to try to work towards having a penetrative sex life again*	Is his partner reacting to BX as BX reacts to his mother in some way? *Th:…if one of you says I don't feel like it today? What will you do about that? Say if your back, was playing up?* *Partner C: if my back was playing up. I would never ever have said that I would not have sex because of it, and BX would often say, that because your back is playing up we haven't done it -in my opinion it would be better than a paracetamol!*	Reflect on this evidence –is this cycle of response a perpetuating factor for her back pain and the ongoing sexual difficulty as a stress/inner conflict-induced PPS? Are we witnessing together an interminable cycle of loss? There is hope today mixed with frustration and despair. Full SI has been possible x1. Take to supervision: Loss/death remain a feature. Plan: Explore further.

Table 8.vi) Participant BX(7)

Participant ID & session no. ( )	What?	So what?	Now what?
BX (7) Couple	BX asks if hypnotherapy might work. *Pt: that it's just involuntary and I mean, I – we were talking, I've never been hypnotised, I don't know whether or not you consider that a valid procedure. I would so love to know if there is anything is subconsciously there I just do not know!*	Is this a subconscious avoidance of facing the pain of the work here? It feels as if there is a block to moving forward, if so, what is its content? *Th: so the worst-case scenario with your mother would be…?* *Pt: I suppose the different thought about… Also…* *Th: about… Let's go through that* *Pt: a different thought about how I thought about her. I suppose in a way, thinking that I had had love for her.* *Th: And her perception of you?* *Pt: just that she becomes, less and more unhappy about things* *Th: so in order to keep that in place, you have to stifle your own feeling self?*	How do we address the fear of loss? Loss of mother's love, loss of love for mother v. his partner walking on egg shells, denying her own sexuality so that they do not lose their love for each other or loss of him through death? Am I imagining all this complexity? We have no consistent change on maintaining reliable, confident erections. No devices appear to work for him, mechanical, medicinal, psychotherapeutic and penile scan shows no blocks to blood flow. Is it that he cannot be direct for fear of damaging or being found wanting....and then having to face loss again? We share this as a disconnect –I feel impotent in the session.

Participant ID & session no. ( )	What?	So what?	Now what?
Cont. BX(7)	BX has the temptation to think of all or nothing in relation to being direct: some of his mother's responses are unacceptable to them both… *Pt: … , if I could say what would happen? I think she would go into depression, that would happen with her.* *Th: If you were fully yourself?* *….Pt: I think, as I say if the opportunity arose, say this anecdote was to be repeated again. Then it would be an opportunity to speak to her…* *Th: that sounds good*	Partner chips in *Partner: I have a level of fury towards her, but I can't even begin to… I can hardly express how I feel, the way that I feel that she has repressed B over the years. I am so furious with her because she is someone who won't speak out openly. She will go all the way round the houses to try and say the one thing that will bring B to heel, or putting down and making feel dependent.*	Both able to speak out : BX expresses fear of potential loss of love from and to mother, which he must protect. Partner expresses fury towards his mother. It sounds as if BX may have inherited some of mother's patterns such as 'going round the houses…' and 'all or nothing'. What does he need next? BX would like a review with a view to a second contract of therapy. The couple report that they have kept enjoyable sexual activity going through the usual hibernation period.

All therapist reflexive memos (link back to Chapter 8.4.)